

Medicine Registration Form

Child's name and	Surname:	
Date of Birth:		Class:
Home Address:		
GP name, Practice	e and phone number:	

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Date	Name of Person Supplying mediation	Name of medication	Amount supplied	Form supplied Liquids/tablets	Expiry date	Dosage regime

My signature is permission for a member of staff to administer the above medication(s). I accept that they are acting on my instructions and they cannot be held responsible if the medicine is not given or given wrongly.

Parent/Carer Signature: Date:

Headteacher Authorisation:

Return of Medication

Date	Person medication returned to	Name of Medication	Amount returned	Reason for returning medication	Parent/Carer Signature	Staff signature (upon filing form)

Register of Medication Administered

Date	Medication	Amount given	Amount left	Time	Administered by		Comments / Action Side effects