Medicine Registration Form

Child's Full Name:_____

Date of Birth:_____ **Class:**_____

Home Address: _____

GP Name, Practice and Contact Number:_____

_____

Details of Medication

Date	Person supplying medication	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 ……

Headteacher Authorisation …….. Date ……..

Return of Medication

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

Register of Medication Administered

Date	Medication	Amount given	Amount left	Time	Administered by		Comments/actions/side-effects