

THURLEIGH LOWER SCHOOL – MEDICATIONS RECORD FORM

Child's Name _____

Class / Tutor Group _____

Name of Medication _____

Strength of Medication if appropriate _____

How much to give (dosage) _____

When to be given _____

Any other relevant instructions _____

Phone Number of adult contact _____

Tick Correct Box: Medicine to be kept at school Medicine to be taken home each day

In consideration for the Head teacher or the school staff agreeing to give medication to my/our above named child during school hours, I/we agree to indemnify the Head teacher, the school staff and the Local education Authority against all claims, costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Head teacher, the school staff or the Local Education Authority.

Parent/Carer Signature. _____

If more than one medication is to be given a separate form must be completed for each.

Date									
Time									
Sig 1.									
Sig 2.									

Date medicine returned to parent/carers on completion of course of medication. _____