



Egloskerry Primary School



Altarnun Primary School



Launceston Primary School

**Record of Medicine Administered to an Individual Child- Temporary Medical Need**

**General Details**

Child's Name:		Class:	
Parent/Carer's Name:		Relationship to child:	
Parent / Carer's consent for this medication to be administered by one member of staff			Yes / No
Staff Member's Name:		Date:	

**Medicine Details**

Name and strength of medicine:			
Storage Instructions (circle)		Ambient / Fridge	
Expiry date:			
Start Date:		End Date (circle)	Specific date _____ / on completion of course

**DOSAGE INSTRUCTIONS**

	Dose 1	Dose 2	Dose 3	Dose 4
Quantity				
Time				

I confirm that a doctor has prescribed the above medication/I am supplying a non-prescribed medication (*please delete as appropriate*).

I confirm my child has had at least one dose of this medicine at home with no adverse reaction.

I give permission for the First Aid trained member of staff to administer the medication to my child during the time they are in school.

I confirm that it is the responsibility of the parent/carer collecting the child, to collect the medication if it is required at home.

Parent/Carer signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff signature: ( <i>Medicine collected from an adult with paperwork completed and signed</i> )	
Person responsible for administering medication	
Staff members informed of medication	

