



**RGS**  
SPRINGFIELD

## MEDICATION FORM

This form should be completed whenever a child receives medication in School which has been supplied by the parent/carer (eg. antibiotics).

CHILD'S NAME	YEAR	D.O.B.			
MEDICATION TO BE ADMINISTERED As described on container				EXPIRY DATE	
DOSAGE REQUIRED	FREQUENCY				
DURATION MEDICATION TO BE TAKEN FOR (No. of days)	TIMES MEDICATION TO BE GIVEN EACH DAY 1. 2. 3.				
<b>DAILY RECORD OF ADMINISTRATION OF MEDICATION</b>					
DATE	MON	TUES	WEDS	THURS	FRI
Time last administered by parent/carer					
Time administered by Springfield Staff. 1. (To be initialled by member of staff each time medication is given + initialled by a staff witness to confirm details as correct). 2. 3.					
ANY OTHER INSTRUCTIONS					
<b>NOTE: Medicines must be in the original container as dispensed by pharmacy.</b>					
The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to Junior School staff administering medicine as instructed.					
Parents Signature _____					
Print Name _____			Date _____		
If more than one medicine is to be given a separate form must be completed for each one.					