RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD

Name of child: _____ **Year group:** _____

Name of medicine: _____

Medicine expiry date: _____

Dose required: _____

Time(s) does to be given: _____

Start date: _____ **End date:** _____

Signature of parent: _____ **Dated:** _____

RECORD OF MEDICINE ADMINISTERED

Date	/ /	/ /	/ /
Time Given			
Dose Given			
Staff Name & Signed:			
Medicine Form completed:			
Date	/ /	/ /	/ /
Time Given			
Dose Given			
Staff Name & Signed:			
Medicine Form completed:			
Date	/ /	/ /	/ /
Time Given			
Dose Given			
Staff Name & Signed:			
Medicine Form completed:			