



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:							