Record of Prescribed Medicines Given to a Child in School

Name of School	FEDERATION OF RIDERS INFANT AND JUNIOR SCHOOLS
Name of Child	
Address of Child	
Date of Birth of Child	
Parent's contact number	

Name of GP	
GP's contact number	

Please tick the appropriate box

My child will be responsible for the self-administration of medicines as directed below	
I agree to members of staff administering medicines to my child as directed below or in case of emergency, as staff may consider necessary	
I recognise that school staff are not medically trained	
I am aged 18 or over	

Signature of parent	
Date of signature	

Name of Medicine	Required dose	Frequency	Course finish	Medicine expiry date
Allergies (if any)				
Special instructions				

Name of child	
Class of child	

No	Date	Time	Medicine Given	Dose	Signature