**Record of Prescribed Medicines Given to a Child in School**

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| --- | --- |
| **Name of Child** |  |
| **Tutor Group** |  |
| **Date of Birth of Child** |  |
| **GP’s Telephone Number** |  |

I agree to members of staff providing medicine/treatment I have supplied to school to my child as directed below or in the case of an emergency, as staff consider necessary.

Parent Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Name of Medicine** | **Dose** | **Frequency/Times** | **Date of Completion** |
|  |  |  |  |
| **Reason for Need:** |  |
| **Special Instructions:** | **Allergies:** |  |
| **Other prescribed medicines child takes at home:** |  |
| **Date** | **Time/Period** | **Medicine Name** | **Dose** | **Staff Signature** |
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| **Date** | **Time/Period** | **Medicine Name** | **Dose** | **Staff Signature** |
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