Testbourne Community School

Record of Prescribed Medicines Given to a Child in School

Medicine with completed form to be brough to reception / first aid room upon arrival at school

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:_____

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**

Date	Time/Period	Medicine Name	Dose	Staff Signature