St John's School

Administration of Medicines

(School policy states that we are only able to administer antibiotics which have been prescribed by a medical official and are to be taken 4 times a day)

Date: _____

Child's Name: _____

Class: _____

Name of medicine: _____

How much to give (i.e. dose) : _____

Time to be given: _____

Any other instructions: _____

Name of persons able to administer medication:_____

Phone no. of parent or adult contact: _____

Name of G.P. : _____

G.P. telephone No. :_____

CONSENT

The above information is to the best of my knowledge accurate at the time of writing and I give my consent to school staff administering the medication in accordance with the school and the department for Education's policy. The school will be notified immediately, of any changes to the above.

Parent's Signature: _____

Print Name: _____

If more than one medicine is to be given a separate form should be completed for each.

Government of JERSEY

RECORD OF MEDICATION ADMINISTRATION

Date D/M/Y	Time Administered	Dose Given	Name of Staff	Staff Signature