



# 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.

# **RECORD OF MEDICATION ADMINISTRATION**

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