



Egloskerry Primary School



Altarnun Primary School



Launceston Primary School

Record of Medicine Administered to an Individual Child- Temporary Medical Need

General Details

Child's Name:		Class:	
Parent/Carer's Name:		Relationship to child:	
Staff Member's Name:		Date:	

Medicine Details

Name and strength of medicine:			
Storage Instructions (circle)	Ambient / Fridge		
Expiry date:			
Start Date:		End Date (circle)	Specific date _____ / on completion of course

DOSAGE INSTRUCTIONS

	Dose 1	Dose 2	Dose 3	Dose 4
Quantity				
Time				

I confirm that a doctor has prescribed the above medication/I am supplying a non-prescribed medication (*please delete as appropriate*).

I confirm my child has had at least one dose of this medicine at home with no adverse reaction.

I give permission for the First Aid trained member of staff to administer the medication to my child during the time they are in school.

I confirm that it is the responsibility of the parent/carer collecting the child, to collect the medication if it is required at home.

Parent/Carer signature: _____ Date: _____

Staff signature: (<i>Medicine collected from an adult with paperwork completed and signed</i>)	
Person responsible for administering medication	
Staff members informed of medication	

