**HOLY ROSARY CATHOLIC VOLUNTARY ACADEMY**

*Part of St Ralph Sherwin Catholic Multi Academy Trust*

**Medication Record**

|  |  |
| --- | --- |
| **Name of Child** |  |
| **Name of Doctor** |  |
| **Name of Medication** |  |
| **Expiry Date** |  |
| **Dosage** |  |
| **Method of Administration** |  |
| **Time(s) at which medication is to be administered** |  |
| **Circumstances in which medication is to be administered (if for emergency use)** |  |
| **Any other action necessary** |  |
| **I confirm that the medication, dosage and timings indicated above are correct and authorise the school to administer them.** | |
| **Parent/Guardian Signature:** | |
| **Parent/Guardian Signature:** | |
| **Date:** | |

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| **Date** | **Quantity Administered** | **Time Administered** | **Signature of staff administering dosage** |
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