

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:		



Holy Rosary Catholic Voluntary Academy

Alexandra Road, Burton-Upon-Trent, DE150JE <u>enquiries@hrb.srscmat.co.uk</u> Tel: 01283 562686 Company Number 7937154





Date	Quantity Administered	Time Administered	Signature of Staff Administering Dosage



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