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:	

Date	Quantity Administered	Time Administered	Signature of Staff Administering Dosage