**Twiss Green Primary School - Administration of Medication**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Year:\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [**Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**](Tel:___________________) **Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, …………………………………………………… (parent/guardian’s name) give permission for the prescription medication(s) listed below to be administered to my child.

**My child had this medicine before with no adverse side effects? Yes/No** If no, unfortunately we will **NOT** be able to administer this medicine. However, you are welcome to come into school and administer it yourself.

**The medicine prescribed must be in its original packaging. (\*Please note, we will only administer medicine prescribed 4 times per day as medicine which has been prescribed 3 times per day, can be administered before and after the school day.)**

Area/location of illness to be treated (e.g. left ear, etc.)..........................................................

Prescribed by …………......……….....…………………..………… on ………………..

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| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Name of Person**  **who brought it in** | **Name of**  **Medication** | **Amount**  **supplied** | **Form**  **supplied** | **Expiry**  **date** | **Dosage**  **regime** |
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**Register of Medication Administered**

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| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Medication** | **Amount given** | **Amount**  **left** | **Time** | **Administered**  **by** | **Comments / Action**  **Side effects** |
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**Register of Medication Administered for....................................................Year........**

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| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Medication** | **Amount given** | **Amount**  **left** | **Time** | **Administered**  **by** | **Comments / Action**  **Side effects** |
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