



Medication Permission and Record: Individual Student

Student's information:

Key Stage: _____

Name of medication: _____

Name of Student: _____

Learning Group: _____

Date provided _____

Any other information: _____

Dose and method (how much and when taken) _____

When is it taken (time of day): _____

Quantity received: _____

Expiry date: _____

Date and quantity of medication returned to parent: _____

Staff Signature: _____

Parent Signature: _____

Print Name: _____

Print Name: _____

Parent contact number: _____



Date			
Time given			
Dose given			
Member of staff			
Staff initials			

Date			
Time given			
Dose given			
Member of staff			
Staff initials			

Date			
Time given			
Dose given			
Member of staff			
Staff initials			

Date			
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Dose given			
Member of staff			
Staff initials			