# Administration of Medication Record

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|---|---|---|---|
| Name of child: | | Date of Birth: | Class: |
| Emergency name and contact number: | | | |

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| Name of medication: | Any special instructions/possible side effects: |
| Formula (e.g. tablets): | |
| Dosage and administering times: | |

| **I hereby authorise the school to administer medicine detailed above:** | |
|---|---|
| Signed: | |
| Print: | |
| Date: | |

| Date & time of administration | Dose given | Name of person administering *(please print)* | Name of person witnessing *(please print)* |
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- I understand that the person who administers the medication will not be medically trained and that is not part of their obligations under their contract of employment.
- I understand that the school staff will take such care as would a reasonable prudent parent and confirm that I will not hold the Governors, the school staff or the Education Authority responsible to any loss, damage or injury resulting from the administration of this medication.