



Administering Medicine Record

Child's Name:	Date of Birth:
Name of Medicine:	Dosage and frequency:
Reason for requiring medication:	
Parent/guardian confirmations: <ul style="list-style-type: none">• I can confirm that the medication supplied is in the original container. I can confirm that my child has already had one dose of this medication and has not suffered any untoward reactions.• I give consent for my child's teacher to administer the above medication, at the stated dosage and frequency.	
Parental/guardian signature: _____	

The box below should be filled out by the child's teacher:

Dosage Given	Time and Date	Teacher Signature	Reactions Witnessed