St Augustine’s RC High School

Administration of Medication in school

|  |  |
| --- | --- |
| Name | Form |
| Medication (please give details of medication below) |
|  |
| I ………………………………… give consent for the above pupil to be given the above medication.Should I wish this dosage to change I will contact school in writing with the new dosage. |
| Dosage required: |
| Signed | Relationship to Pupil  |

Register of Medication Administered

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| **Date** | **Medication** | **Amount given** | **Amount left** | **Time** | **Administered by** |
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