Administration of Medication in school

Name ____ Form ______________

Medication ____

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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

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