LEIGHTON MIDDLE SCHOOL MEDICINE RECORD

Child's Name: _____

Form Group: _____

Name of Medicine: _____

Strength of Medicine: _____

Reason for Medicine: _____

How much to give (dosage): _____

When to give: _____

Any other instructions: _____

Phone No. of adult contact: _____

Tick appropriate box:

Medicine to be left in School: ☐

Medicine to be taken home each day: ☐

Course of medicine: Start date _____ End date _____

In consideration for the Headteacher or the School's staff agreeing to give medicine to my/ our above named child during school hours I/ we agree to indemnify the Headteacher, the School's staff and the Local Authority against all claims, costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Headteacher, the School's staff or the Local Authority.

Parents signature: _____ Date: _____

If more than one medicine is to be given a separate form should be completed for each Date medicine returned to parent on completion of course of medicine

DATE										
TIME GIVEN										
SIGN										