Administration of Medication Record (Form Med 2) Sheet number.....

(In chronological order)								
Name of Provis	sion		Co	Cononley Primary School				
Name of child/y	oung per	rson		Do	οВ	Class or group		
Name of GP ar	nd contac	t number						
Emergency name and contact number								
Name of medication			Any special instr	uctions				
Formula (e.g. tablets)								
Dosage and ad	lministerir	na times						
			,					
Date & time of	Dose given	Any reactions	Name of person(s) administering /	Signature of person(s)	Additior e.g.	nal information		
administration	9	and any	supervising (please	administering /	• Repe	eat prescription		
		action taken by staff	print)	supervising	supp • Medi	lied cation returned		
		-			to pa			

Date & time of administration	Dose given	Any reactions and any action taken by staff	Name of person(s) administering / supervising (please print)	Signature of person(s) administering / supervising	Additional information e.g. • Repeat prescription supplied • Medication returned to parent • Medication returned to pharmacy (Pharmacist signature required) • Parents signature (Early Years Children only)
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Date & time of administration	Dose given	Any reactions and any action taken by staff	Name of person(s) administering / supervising (please print)	Signature of person(s) administering / supervising	 Additional information e.g. Repeat prescription supplied Medication returned to parent Medication returned to pharmacy (Pharmacist signature required) Parents signature (early years only)