# ROSEACRE JUNIOR SCHOOL
# SCHOOL MEDICINE RECORD

To be completed by the parent/guardian. If more than one medicine is to be given, a separate form should be completed for each.

Child's Name:_____ Class:_____

Name of Prescribed Medicine: _____

(Only prescribed, four times daily medication may be administered.)

Ailment/Reason for Medication:_____

Dosage:_____

Time to be given: _____

Any other instruction (includes details for inhalers, if any) and particular circumstances requiring medication (i.e. asthma):_____

DECLARATION

I request that the above medication be given in accordance with the above information by a responsible member of the school staff who has received any necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out of school activities, as well as on the school premises.

I undertake to supply the school with medicines in properly labelled containers within their use-by date.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent, and that the school staff may therefore need to arrange any medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

Parent or Guardian Contact No:

Home:_____

Work:_____

Mobile:_____

SIGNED:_____
(Parent/Guardian)

PRINT NAME:_____

DATED:_____