

RECORD OF MEDICINE ADMINISTERED AT SCHOOL (AS & WHEN)

Name of child:	Class:
Medicine:	
Time to be given:	Dose:

I give permission for the first aiders to administer the above medicine.

Parent's signature:	Date:
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OFFICE USE ONLY

Date:				
Time given:				
First aider:				

Date:				
Time given:				
First aider:				

Date:				
Time given:				
First aider:				

Date:				
Time given:				
First aider:				

Date:				
Time given:				
First aider:				