School/Nursery Medication Record **Please Print Double Sided**

Prior to administration please check against the medication form and medication label; **RIGHT person** (ask to state their name) **RIGHT dose** **RIGHT medication** **RIGHT route** (oral, topical etc.) **RIGHT time** (as prescribed OR minimum time passed between doses)	• **Medication should not be accepted unless it is sealed in the original packaging with information leaflet inside (with the exception of short term antibiotics).** • **Pharmacy labels should be clearly legible.** • **Please check the medication has not exceeded the expiry date.**

Pupil's name: **Date of birth:** **Class:**

Date	Time	Name of Medication	Dose and route	Amount	Name of giver PLEASE PRINT	Signature of giver	Amount actually taken by pupil
01/01/01	00:00	Paracetamol	120mg Oral	5mls	JOHN SMITH	*John Smith*	all/spat/refused

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