Administration of Medication Record (Form Med 2)

Sheet number…….

(In chronological order)

Name of school/setting			
Name of child/young person		DoB	Class or group
Name of GP and contact number			
Emergency name and contact number			

Name of medication	Any special instructions
Formula (e.g. tablets)	
Dosage and administering times	

Date and 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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