CASTLE LOWER SCHOOL

SCHOOL MEDICINE RECORD

Child's Name	
Class	
Name of Medicine	
Strength of Medicine	
How much to give (i.e. dose)	
When to be given	
Any other instructions (inc details for inhalers)	
Phone No. of parent or adult contact	
Medicine to be left at school	**Yes / No *** ***Delete as appropriate**
Medicine to be taken home (e.g. antibiotics)	**Yes / No *** ***Delete as appropriate**

In consideration for the Headteacher or the School's staff agreeing to give medication to my above named child during school hours, I agree to indemnify the Headteacher, the School's staff and the Local Authority against all claims, costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Headteacher, the School's staff or the Local Authority.

Parent's signature …….. Date …….

Date												
Time												
Initials												