Head Teacher: Dr. Arshad Jamal
Early Years Manager: Mrs. Assayia Shazad
117 Tennyson Road, Luton, Bedfordshire, LU1 3RR Tel: (01582) 518800 E-mail: admin@oakwoodprimary.co.uk

Administration of Medicine

Child's Name:	
Class:	
Gender:	
Age:	
Date of Birth:	

Name of Medicine: ....

Medical Condition / Illness: (please provide details)
....
....
....
....
....

Who was the medication prescribed by?: *Dr / Medical Practitioner* ☐ *Nurse* ☐ *Parent / Guardian* ☐

Doctor / Nurse's Name: .... **Surgery Telephone Number:** ....
Medical Surgery Address: ....

Type/Form of Medication: *Inhaler* ☐ *Tablet* ☐ *Syrup* ☐ *Other* ☐ (please specify) ....

Medication Expiry Date: ....

Please specify the start/end date of when the medication should be administered from:

Start Date: .... *End Date:* .... *Number of Days in Total:* ....

Duration: (length of time medication must be administered for) *Permanent* ☐ *Temporary* ☐

How much medication must be administered? (delete as appropriate) .... *puffs / drops / ml*

How many times a day?: (circle as appropriate) 1 2 3 4 5 *Other* (please specify) ....

Please specify what times the medication must be administered daily:

1) .... am/pm **2)** .... am/pm **3)** .... am/pm **4)** .... am/pm **5)** .... am/pm

Any Additional Notes: ....
....
....

Is the medication required to be returned to the parent? (If yes, please tick appropriately) Yes / No

Yes – *At the end of each day* ☐ Yes – *By the end of the medication course* ☐

Consent of Parent / Guardian

Full Name: .... Contact Telephone Number: ....
Postal Address: ....
Relationship to Child: .... E-mail Address: ....

Parent/Guardian's Name:	Signature:	Date: