

**Class/ Year Group:**

**Pupil Name:**

Med Form 2a

RECORD OF MEDICATION ADMINISTERED IN NAME SCHOOL or administration of controlled drugs

Date medicine supplied to school: Storage Point: Date medicine finished/sent home:

This form is for schools to record details of medication given to pupils. **NB! Two staff to sign for administration of all medication** (when complete store in child’s PPR).

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Name of Medication** | **Quantity at start****(ml or no. of tablets)** | **Dose given** | **Quantity that remains****(ml or no. of tablets)** | **Any Reactions** | **Other recording (e.g. blood sugar level)** | **Signature of Staff** | **Print Name** | **Signature of Staff** | **Print Name** |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Signature of Head Teacher or designated person (DHT, PT ASL, PTG): |  | Date: |  |