

**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).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |
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| Signature of Head Teacher or designated person (DHT, PT ASL, PTG): | | | |  | | | | Date: |  | | |