Learning for life

Green Shoots
INTERNATIONAL SCHOOL

Medication Form

Name of child _____ Date of Birth_____

Details of medical condition

_____

Name of medication/herbal remedy to be administered _____

Dosage to be administered ____ _____

How often to be administered _____

Time/date of last dosage _____

Has your child had this medication previously YES/NO

If yes please provide details of any reactions _____

Record of Medication/Herbal Remedy Administered					
Date	Time	Amount	Signature of Parent	Signature of staff member who administered the medication	Reaction to dosage given

Name of authorising Parent _____

Signature of Parent _____

Date _____

Please note: only medication/herbal remedies in their original packaging will be accepted