The Ruskington
Chestnut Street CofE Primary School

Name: _____ Date of Birth: _____

Address _____

_____

GP _____ Allergies. _____

Class _____

CARE PLAN REQUIRED for long term medicines	YES	NO

Register of Medication Obtained

Date	Name of Person Who brought in the Medication	Name of Medication	Amount Supplied	Tablet or liquid	Expiry Date	Dosage Regime	Received By

Date	Medication	Amount Given	Amount Left	Time	Administered By		Comments / Action Side effects

I understand I must deliver the medication personally to the school office. I agree to the designated member of staff administering the medication on my behalf.	
Signed **Name**	**Relationship** **Date**

The Ruskington
Chestnut Street CofE Primary School

Date	Medication	Amount Given	Amount Left	Time	Administered By		Comments / Action Side