Record of Medicine Administered to a Student

Penwortham Girls' High School

Name of Pupil: **Form**:

Date medicine provided by parent	
Quantity Received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature: _____

Signature of parent/carer: _____

Date: _____

Date:-	Time given:-	Dose given:-	Name of Staff:-	Witnessed By:-

Date:-	Time given:-	Dose given:-	Name of Staff:-	Witnessed By:-