Barr Beacon School
Prescribed Medication Record

Child's Name_____ Tutor Group_____

Medication name_____

Date course starts _____

Date course finishes_____

Parent/Carer signature_____

Signature of staff member receiving medication _____

Headteacher/Deputy Headteacher Signature _____

Date_____

Instructions….

P.T.O.

This section must be completed by the member of staff administering the prescribed medication, ensuring the following details are completed:

Date	Time	Dosage	Signature

Amount of medication left at end of course _____

Staff signature_____

Signature of parent/carer collecting excess medication _____

Date_____