RAYNSFORD ACADEMY
MEDICINES FORM

Child's name	
Class	
Name of medicine	
EXPIRY DATE	
Strength of medicine	
How much to be given	
Asthma Triggers (if applicable)	
When to be given	
Where to be stored	
Medicines to be left at school	Yes/no Please ring the correct one
Contact numbers for responsible adult	Home: Mobile:

In consideration for the Head teacher or the School's staff agreeing to give medication to my above named child during school hours, I agree to indemnify the Head teacher, the School's staff and the Local Authority against all claims, costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Head teacher, the School's staff or the Local Authority.

Parent's signature …… Date …….

Date										
Time										
Initials										
Initials										
Collected (initials)										