

Name of medication \_\_\_\_\_

Dosage (how much) \_\_\_\_\_

Frequency (how often a day) once / twice

**\* All medications are given at 12.30am - 1:00pm. Please state if the medication should be given at any other time.**

How it is to be given: (please circle) By mouth / By Inhalation / Applied to skin /

Ear drops / Eye drops

Please state any precautions or possible side effects that you are aware of:

\_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

Members of staff agreeing to the responsibility should be satisfied that enough information and instruction is provided to allow the procedure to be carried out safely.

Signature of staff member accepting \_\_\_\_\_

Date: \_\_\_\_\_

Copy: in office file/Medical file/Class teacher



## Medical Care Plan

