FERNHURST JUNIOR SCHOOL
Together Towards Success

MEDICATION RECORD

Child's Name: _____ **Class:** _____

Date: _____

Medicine to be taken: _____

Reason: _____

Dose: _____

Time to be taken and dates to and from: _____

_____

_____

I give permission for my child to take the medicine under supervision and according to the details above.

Signed: _____
(Parent/Guardian)

Medicine Record

Date	Time	Staff Initials