Medication & treatment record

CHILD'S NAME		YEAR LEVEL		TEACHER'S NAME	

MOTHER'S HOME PHONE NO		FATHER'S HOME PHONE NO	
MOTHER'S WORK PHONE NO		FATHER'S WORK PHONE NO	

FIRST EMERGENCY CONTACT:

NAME:		RELATIONSHIP TO CHILD	
PHONE NUMBERS:	HOME:	WORK:	

SECOND EMERGENCY CONTACT:

NAME:		RELATIONSHIP TO CHILD	
PHONE NUMBERS:	HOME:	WORK:	

Illness/condition being treated	Describe symptoms	Medication (if required) to be given	DOSAGE	FREQUENCY	Maximum no of doses per day

If the condition doesn't improve within ……..please indicate further action required below. (For children who suffer severe Asthma, an individual Asthma mask, pump and also the appropriate pump medication supplied with dosage instructions (All clearly named).

FAMILY DOCTOR		DOCTOR'S TELEPHONE NO	

FURTHER ACTION REQUIRED

ANY ALLERGIES TO:

MEDICATION (please describe)	FOODS & OTHER ENVIRONMENTAL INFLUENCES (please describe)

Parent's/Guardian's Signature……. Date:……..

FOR SCHOOL USE ONLY

Date Medication Given	Time Medication Given	Name of Medication	Dosage	Any other action taken	Name of treating staff member	Other details