Individual Medical Record

Name of Student …… Form …….

Medical Condition	
Date medication prescribed.	
Expiry date	
Dose and frequency of medicine OR Health-care procedure	
Quantity received	
Quantity returned	
Parental agreement with the school ***(Please tick agreed box)***	☐ Student will self-manage all medical needs without assistance. ☐ Student will self-manage but may need some assistance. ☐ Student will need a trained medical administrator

I confirm that the medication is in it's original packaging and that the following details are clearly identified by the prescriber: my daughter's/ son's name, date medication was prescribed, expiry date, prescribed dose and any relevant advice about how to administer the medication.

Does your daughter/ son have a long-term medical condition e.g. diabetes, asthma, heart condition etc?

Yes ☐ No ☐

If you have answered yes to the question above, have you agreed a Health Care Plan with the school (SENDCo) ?

Yes ☐ No ☐

Parent's/ Carer's Signature …….. Date……..

Name of Student …… Form ……..

Student will self-manage all medical needs without assistance

Date	Time	Dose Taken	Student's Name (print)	Student's Signature

Name of Student …… Form ……..

Student will need a trained medical administrator.

Date	Time	Dose given/care procedure administered	Name of trained administrator (print)	Staff Signature