Medicine Record

Child's Name   _____

Class   _____

Illness being treated   _____

Name of medicine   _____

Expiry date   _____

Dose to be given   _____

Time(s) to be given   _____

Does this medicine need to be refrigerated? _____

Quantity provided (if relevant)   _____

Where / when to administer (cream based) _____

Parent Signature   _____

Date   _____

Date	Time	Dose	Staff Name