newstruan school

Included, confident learners in the community

Medication Profile

Childs Name: Parents/Carers:

Date of Birth: Address:

Date Recorded: Phone Number:

POM MEDICATION (prescribed only meds)	**Daily**	**As Required**	**Dosage**	**Time**

Preferred Method of Administration: (if covert must have confirmation from GP and parents)

Homely Remedies	**Daily**	**As Required**	**Dosage**	**Time**

Preferred Method of Administration (if given covertly must have confirmation from GP and parents)

Important Information (i.e. Allergies)

Staff Signature: _____

Parent Signature: _____

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Reason for medication prescription

Medication Name	Prescribed for the treatment of