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/CONDITIION 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 should be supplied for school use and also the appropriate pump medication supplied with dosage instructions (ALL CLEARLY NAMED). Children with Asthma who use a puffer should supply two units to school - one for storage in the classroom and one for storage in the sick bay).

FAMILY DOCTOR:		DOCTOR'S TELEPHONE NO:	

FURTHER ACTION REQUIRED:

ANY ALLERGIES TO:

(A) MEDICATION (please describe)	(B) 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