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| **Medication received** | | | | **Medication returned** | | | | **Record of Seizures** | | |
| **Date** | **Medicine** | **Qty** | **Sign** | **Date** | **Medicine** | **Qty** | **Sign** | **Time** | **Duration** | **Action Taken** |
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* All medication must be in the original bottle or box, with the pharmacist’s label attached.
* The label must include the child’s name, medication name, strength, dose and time of administration. It is not permitted to administer medication from a container that says, ‘as directed’.
* Labelling must correspond to the written instructions from the GP, consultant or parent.
* Any discrepancies should be brought to the attention of the parent.

**Regular Medication Recording Form**

**Child’s Name:**      **GP’s Name:**       **Parent(s):**

**Date of Birth:**      **GP’s Tel:**      **Parent(s) Tel:**

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|  |  | w/c |  |  |  |  |  |  | w/c |  |  |  |  |  |  | w/c |  |  |  |  |  |  |
|  | time | m | T | w | t | f | s | s | m | t | w | t | f | s | s | m | t | w | t | f | s | s |
| medication: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| medication: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| medication: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| medication: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| medication: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Start date: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Occasional Medication Recording Form**

**Child’s Name:**      **GP’s Name:**       **Parent(s):**

**Date of Birth:**      **GP’s Tel:**      **Parent(s) Tel:**

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| **Date** | **Medicine** | **Dose** | **Method of**  **Administration** | **Parental**  **Consent** | **Time of**  **Administration** | **Signed on**  **Administration** | **Refusal of Medication/**  **Side Effects/Observations** |
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