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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: |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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| medication: |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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| Start date: |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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**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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