Medication Administration Form 2025-2026

The academy will not administer medicine unless you complete and sign this form.

Name of student:		**Group / class / form:**	
Date of birth:		**Date form submitted:**	
Name of parent:		**Parents signature / consent:**	

Medical condition / illness:

Medicine/s: ***Please continue on another sheet if you require more space – this must be attached and signed***

Name and type of medicine	Amount provided	Dosage, method and timing	Date dispensed	Expiry date

Special precautions / other instructions:

Are there any side effects to the medication/s that the academy needs to know about?

Self-administration: ***(delete as appropriate)*** **Yes / No**

To be completed by the academy:

Medication start date:	
Medication end date:	
Review to be initiated by:	
Agreed review date:	

Ormiston Academies Trust

Ormiston Sudbury Academy

RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL STUDENT 2025/2026

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
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