TOWN CLOSE SCHOOL

NORWICH'S FINEST PREP SCHOOL • FOR GIRLS & BOYS • 3-13 YEARS

MEDICINE FORM (I)
THE ADMINISTRATION OF PRESCRIBED MEDICATION DURING A RESIDENTIAL TRIP

Child's Name: _____ **Form:** _____

Please complete the following table with details of any prescribed medication your child will need during the overnight trip. **The medication must be delivered to the trip first aider with the completed form.**

Medication		Condition for which it is prescribed:		
Medication		Condition for which it is prescribed:		
Dates that medicine is to be administered	Time	Dosage of medicine to be given	Signature of person administering prescribed medicine	Signature of witness
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				

Parent's name: _____

Signature: _____ **Date:** _____

Medication		Condition for which it is prescribed:		
Dates that medicine is to be administered	Time	Dosage of medicine to be given	Signature of person administering prescribed medicine	Signature of witness
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
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