**Permission to Administer Medication and Medication Record**

Medications will only be given to children in line with our medication policy.

The setting will not give your child medicine unless you complete and sign this form.

|  |
| --- |
| **Details of Child:** |
| Full name: |  | Date of birth: | \_ \_/\_ \_/\_ \_ \_ \_ |
| Address:  |  |
| Key person: |  |
| Condition of illness: |  |
|  |  |
| **Medication:** |
| Name/type of medication (as described on the container): | Prescribed by: |
| For how long will your child take this medication: |  |
| Date dispensed: | \_ \_/\_ \_/\_ \_ \_ \_ |
| **Full directions for use:** |
| Dosage and method: |  |
| Timing: |  |
| Time and date last dose given |  |
| Special precautions: |  |
| Side effects: |  |
| Staff to administer or self administration: |  |
| Procedures to take in an emergency: |  |
| **Contact Details:** |
| Name: | Relationship to child: |
| Contact telephone numbers(while medication is being given): |
| I understand that I must deliver the medicine personally and accept that this is a service that the Pre-school is not obliged to undertake.Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_ \_/\_ \_/\_ \_ \_ \_ |

**Administration of Medication Form**

**Child’s Name:**

**Medication:**

**Staff administered or Self- administered**

**Medication checked for child’s name, dosage and expiry date: Yes**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Dosage** | **Staff Signature** | **Witness****Signature** | **Parent’s Signature** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |