**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** |
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