MEDICATION FORM

Name of the child: _____Date of birth_____

INSTRUCTIONS RECEIVED BY THE PARENT/CARER

Please state below the date, time and reason this medication was last administered:

Date: _____ Time: _____ Reason: _____

Please complete the information below relating to administration of medication:

Date Required: _____ Time/Times Required: _____

Name of medication: _____

The dosage required: _____

Reason for this medication: _____

Any special storage requirements:: _____

Please circle the relevant information. This medication is: **Prescribed** or **Non Prescribed**

Name of parent requesting administration of this medication: _____

Signature of parent: _____

Name of staff member: _____ can confirm they have read and understood all instructions given by the parent

DISPENSED BY DAY CARE PROVIDER

Date and Time/Times	Name of Medication	Dosage administered	Name of staff member who administered medication	Name of witness to administration of medication	Name of parent to confirm they have been informed of medication administered

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