

## Administering of medicine form

Medicines must be in the original container as dispensed by the pharmacy

Medication will be stored	
in	

## To be completed by parent:

Name of child	Child's DOB	
Medical condition/illness	Is specialist training required?	Y/N IF YES PLEASE STATE
Name of medication (as stated on the packaging)	Expiry date	
Method of administration	Dosage	
Time medicine is to be administered	Are there any side effects that the setting needs to know?	
Signed by Parent	Date	

## To be completed by staff member:

Date	Time given	Dose given
Staff name & signature	Witness signature	Parent signature
oignaturo	Signature	Signature
Date	Time given	Dose given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
		given
Staff name &	Witness	Parent
signature	signature	signature

Date	Time given	Dose	
		given	
Staff name &	Witness	Parent	
signature	signature	signature	

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Date	Time given	Dose
Staff name &	Witness	given
signature	Witness signature	Parent signature
Signature	Signature	Signature
Date	Time given	Dose
Bate	Time given	given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
		given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
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Staff name &	Witness	Parent
signature	signature	signature
	I	
Date	Time given	Dose
Ctoff name 9	Witness	given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
Date	Time given	given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
	<u> </u>	given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
		given
Staff name &	Witness	Parent
signature	signature	signature
Date	Time given	Dose
01.5	1000	given
Staff name &	Witness	Parent
signature	signature	signature