

**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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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

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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