QUACKERS BREAKFAST AND AFTER SCHOOL CLUB

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? If yes, *name of staff *date *by whom.	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	

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

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

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

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