Administering Medicine Record

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| **Child’s Name** | **Date of Birth** |
| **Date form is completed (Today’s date)** | **Prescribed Medicine**  **Over-the-counter Medicine** |

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| **Name of Medication (full title)**  **Dosage and frequency**  **Reason for requiring medication** |

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| **Parent Confirmation**  **I confirm that the medication supplied is in the original container. I confirm that my child has already had one dose of this medication and has not suffered any untoward reactions.**  **I give consent for a First Aider to administer the above medication, at the stated dosage and frequency to my child.**  **Parent’s Signature** ………………………………………………………… |
| |  |  |  |  | | --- | --- | --- | --- | | Dosage Given | Date / Time | Name a& Signature of Chaperone |  | |  |  |  |  | |  |  |  |  | |