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** ………………………………………………………… |
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| Dosage Given |  Date / Time | Name a& Signature of Chaperone |  |
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