ROYAL NAVAL PRE-SCHOOL LEARNING ORGANISATION

ADMINISTRATION OF MEDICINES IN PRE-SCHOOLS.

Name of person completing form _____

Name of setting ----------

Name of child ----------

Date ----------

Reason for medication ----------

Name of medication ----------

Possible side effects ----------

Expiry date ----------

Dosage to be given ----------

Time to be given ----------

Time of last dosage given at home ----------

I confirm that the above medicine has been prescribed by a doctor, and that I give my permission for the group leader or an assistant to administer the medicine to my child during the time they are present at the setting.

Signed **date**

Name
(Parent /guardian /person with responsibility)

Date	Dosage	Staff no 1	Staff no 2	Time administered	Parent/carer signature