MEDICATION FORM

Name of Child: ______ **Date of Birth:** ______

Room: ______ **Has your child had this medication before?** **Yes** ☐ **No** ☐

Has this medication been recommended by a Pharmacist without a written Prescription?
(If YES please could parent/ guardian sign below. If No we will be unable to administer medication.) **Yes** ☐ **No** ☐

Signed: ______ **Date:** ______
Parent / Guardian

Name and strength of medication: ______

Dose and frequency: ______

Medication handed to: ______

Injuries as a Result of Incident/Accident: ______

I <u>give my permission</u> for the above medication to be administered to my child.

Name: (Please Print) ______ **Relationship to child:** ______

Signed: ______ **Date:** ______
Parent / Guardian

Please inform us of any change in dosage during this period.

PLEASE ALSO GIVE TIME OF LAST DOSE GIVEN AT HOME BEFORE THE START OF EACH SESSION.

DATE	TIME	DOSAGE	PARENT SIGN	STAFF SIGN	WITNESSED BY

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