**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 |  |