**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/NIF 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 |  |

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| --- | --- | --- | --- | --- | --- |
| Date  |  | Time given  |  | Dose given  |  |
| Staff name & signature  |  | Witness signature |  | Parent signature |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date  |  | Time given  |  | Dose given  |  |
| Staff name & signature  |  | Witness signature |  | Parent signature |  |

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| --- | --- | --- | --- | --- | --- |
| Date  |  | Time given  |  | Dose given  |  |
| Staff name & signature  |  | Witness signature |  | Parent signature |  |