**Medication Sheet**

**Permission to administer medication or treatment for one day only.**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of medication or treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage required: \_\_\_\_\_\_\_\_\_

Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Times to be administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has this medication been administered in the last 24hrs? Yes/No/Unsure (***Please circle)*

*Where it is unsure if the child has had any medication in the last 24hrs, it is the Senior Practitioner’s responsibility to decide whether the child has been in attendance for a long enough period to be clear of any administering requirements stated on the label, in line with our consent forms signed by parents and only given in emergency or high-risk situations.*

Last dose given at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Only applicable if permission obtained over the phone:**

Staff name of who contacted parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contacted by: Email/Phone/Text *(Please delete appropriately)* Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Staff sign to confirm permission was authorised as stated above, including advanced signed permission in child’s personal details.* Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details of administration:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time**  | **Dose** | **Administered by**  | **Staff Sign** | **Witnessed by**  | **Parent sign** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Senior Practitioner’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*It is the Senior Practitioner’s responsibility to check labels on prescribed medication or relevant information on over the counter medicines to ensure suitability and dosages before signing this form and administering medication.*

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_