LITTLE SUNBEAMS PRE-SCHOOL

ADMINISTRATION OF MEDICINE AND TREATMENT CONSENT FORM

Name of child	

Medical condition or illness	
Date diagnosed	

Name of Medicine (and strength)	Required Dose	Frequency	Course Finish	Medicine Expiry Date

Any special instructions for storage of medicines (e.g. needs refrigeration)	

Procedures to be taken in an emergency	

Are there any side effects that we need to be aware of?	YES/NO (If YES please give details)

Other Prescribed Medicines child is currently taking	

Any known Allergies	

PARENTAL AGREEMENT

I understand that I must personally hand, any medicines prescribed for my child, to a manager of the setting.

I understand that ALL medication must be in the original container / box and must be clearly labelled with the pharmaceutical label showing the child's full name, date of dispensary and dosage instructions.

I agree to members of staff administering medicines/providing treatment to my child as directed above, or in the case of an emergency, as staff may consider necessary.

I accept that this is a service that the setting is not obliged to undertake and I recognise that staff are not medically trained.

I understand that I must notify the setting of any changes in writing.

Signature of parent/carer	
Date of signature	

Agreed date of review (if applicable)	

Signature of manager	
Date of signature	

Date	Time	Medicine or Treatment given	Dose	Signature of administering staff member	Signature of witnessing staff member	Signature of Parent/Carer