

Permission to Administer Medication and Medication Record

Medications will only be given to children in line with our medication policy.

The setting will not give your child medicine unless you complete and sign this form.

| Details of Child: | | | |
|-----------------------|--|----------------|-----|
| Full name: | | Date of birth: | / / |
| Address: | | | |
| Key person: | | | |
| Condition or illness: | | | |

| Medication: | |
|--|------------------------|
| Name/type of medication (as described on the container): | Prescribed by: |
| For how long your child will take this medication: | |
| Date dispensed: | / / |
| Full directions for use: | |
| Dosage and method: | |
| Timing: | |
| Time and date last dose given | |
| Special precautions: | |
| Side effects: | |
| Staff to administer or self administration: | |
| Procedures to take in an emergency: | |
| Contact Details: | |
| Name: | Relationship to child: |
| Contact telephone numbers (while medication is being given): | |
| I understand that I must deliver the medicine personally and accept that this is a service that Northleaze After School Play Club is not obliged to undertake. | |
| Signature | Date / / |

Administration of Medication Form



Child's Name:

Medication:

Staff administered

Self-administered

Medication checked for child's name, dosage and expiry date:

| Date | Time | Dosage | Staff Signature | Witness Signature | Parent's Signature |
|------|------|--------|-----------------|-------------------|--------------------|
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[In line with your GDPR responsibilities, be sure to direct all parties named in this document to your privacy statement]

Date to be reviewed: October 2025

Date amended: October 2023

Date signed off: October 2023

Signed: Kathleen Williams

Signed: Tom Colquhoun