



# Medication Administration Consent and Record Form

**For all prescription, complementary and over-the-counter medications**

Child and Parent/Carer Details												
Child's First and Last Name:									Class name:			
Date of Birth (DOB):									Child's Known Allergies:			
Parent/Carer First and Last Name:									Contact phone number for today:			
Parent/Carer to fill in details in this section												
Medication Details					Last Dosage Given			Administration for Today		Name of staff member who discussed and checked parent instructions	I give permission for the use of this medication for my child as detailed and discussed this with my child's teacher. <u>Parent/Carer signature:</u>	
No.	Date DD/MM/YY	Name of Medication Eg Amoxicillin	Expiry Date MM/YY	Reason for Use Eg Respiratory Tract Infection	Date	Time	Dose and how it was administered Eg orally with food	Time of next dose at school	Dose and administration instructions Eg orally 1 hour before lunch with water			
1.												
2.												
3.												
4.												
Additional Parent/Carer instructions:												
1 <sup>st</sup> staff member to record details. 2 <sup>nd</sup> staff member to confirm all details and witness administration. Store in child's student file.												
<input type="checkbox"/> Medication's original label/container checked												
No.	Name of Medication	Date Given	Time Given	Dose and administration manner	1 <sup>st</sup> Educator's Name	Signature	2 <sup>nd</sup> Educator's Name	Signature				
1												
2												
3												

Comments (if any);



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No	Name of Medication	Date Given	Time Given	Dose and administration manner	1 <sup>st</sup> Educator's Name	Signature	2 <sup>nd</sup> Educator's Name	Signature

**Comments (if any);**