



Medicine Form

Child's Surname: _____

Child's First Name (s): _____

Reason for Medicine: _____

Name of Medicine: _____

Expiry Date: ____ / ____ / ____

Storage Requirements: _____

Dosage and Times to be administered: _____

I have read and understood the Administration of medicines Policy. I give permission for the staff to administer the medicine(s) listed on this form to my child.

Signature of parent/carer: _____ Date: ____ / ____ / ____

For Office Use only

Date and Time Given	Dosage	Given By	Witnessed By	Parent/Carer to sign on collection

If you have any questions or comments please speak to the Play Scheme Supervisor or Duty Manager.

Members of staff at the centre will not be able to administer medication to your child if you do not complete and return this form. Under no circumstances will members of staff administer medication against the will of a child.