



Request for Setting to Administer Medication

This information will be held securely and confidentially and will only be shared with those who have a role or responsibility in managing the administration of medication for your child.

This form **MUST** be completed by the child's parent / carer before the request can be considered.

Child's Details:

Name: _____ DOB: _____

Address: _____

Parent/carer name and contact number: _____

Emergency contact name(s) and number(s): _____

Details of Medication:

Medical condition/illness _____

Medication name and strength _____

Medication formula (e.g. tablets) and amount given to the setting (e.g. number of tablets supplied)

NB Medications MUST be in the original container as dispensed by the pharmacy.

Dosage and frequency/time of administration: _____

Details for storage: _____

Administering instructions: _____

Any known side effects: _____

Potential Emergency Details.

What would you constitute as an emergency? _____

What to do in an emergency: _____

Parental Statement Consent

I (printed name of parent/carer) _____

- * Request and give my consent to the setting administering this medication in accordance with the prescriber's instructions.
- * Confirm that the information and instruction given is accurate and up-to-date.
- * Will inform the setting in writing of any changes to this information and instructions.
- * Understand that the medication may be given by non-medically qualified staff.
- * Agree to not hold staff responsible for loss, damage or injury when undertaking agreed administration of the medication unless resulting from their negligence.
- * Will abide by the setting's policy and procedure for the delivery and return of medication.
- * Will ensure adequate supply of the medication that is within its expiry date.

Signature of parent / carer _____ Date: _____

Settings Statement of Agreement

Name of setting: _____ agrees to administer this medication.

- * In accordance with the prescriber's instructions
- * Until the end of the course of medication or until instructed otherwise in writing by the parent/carer

Name of Manager (Please print) _____

Signature of Manager: _____ Date: _____

NB The manager must establish that the appropriate knowledge, training and insurance requirements for the giving of this medication are met before agreement is given.

If more than one medication is to be given than a separate form must be completed for each.



Administration of Medication record

Sheet number:.....

Date and time of administration	Dose given	Any reactions and any actions taken by staff	Name of person(s) administering / supervising (please print)	Signature of person(s) administering/ supervising	Additional information e.g. <ul style="list-style-type: none">• Repeat prescription supplied• Medication returned to parent• Medication returned to pharmacy (Pharmacist signature required)• Parents signature (EYFS)

Name of Child:

Sheet number: