Short Term Medication form

Child's Name		Date of Birth	

Date this is completed (today's date)	

Name of medication (full title)	
Dosage and frequency (incuding times where appropriate)	

Reason for requiring medication

Prescribed medication		Over-the-counter medication	
In original box or bottle		In original box or bottle	
Full instruction leaflet included		Full instruction leaflet included	
Has original pharmacy label		Labelled with child's name	
Child's name correct		Dose specified	
Child's date of birth correct		Medicine is in date	
Dose specified			
Medicine is in date			

Special storage required?	Yes ☐	No ☐	Details:

I confirm that the medication supplied is in the original container. I confirm that my child has already had previous doses of this medication and has not suffered any untoward reactions.	
I give consent for the setting to administer the above medication, at the stated dosage and frequency, as and when required, to my child. I will inform the setting of any doses given at home before arrival.	
Parent's Signature:	

Previous dose given by parents/carers should also be recorded on this table.

Date	Time	Dosage Given	Administered By	Practitioner Signature	Witness Signature & Name	Parent/Carer Signature

Staff Signature:	

Headteacher/Senior Manager Signature:	