

Medication sheet

Name of child:

| | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Medication to be administered: | | | | |
| Dose: | | | | |
| Frequency: e.g. Time of day before meal with meal after meal | | | | |
| | Time and staff signature | Time and staff signature | Time and staff signature | Time and staff signature |
| Monday | | | | |
| Tuesday | | | | |
| Wednesday | | | | |
| Thursday | | | | |
| Friday | | | | |
| | | | | |
| | | | | |
| | | | | |

I consent for a member of staff to administer medication to my child in my absence.

Signed.....

Date:.....

Print name.....