

Foundations Community Pre-School Ltd Medication Record

Date Medication to be Taken _____

Full Name of Child _____ D.O.B. _____

Parents/Carers Name _____

Name of Medication _____ Expiry Date _____

Prescribing Doctor _____

Dose and time last given _____

Why it was given _____

Time to be taken _____ **Dose to be given** _____

How is it to be administered _____

Staff Signature _____ Parent/carer Signature _____

Staff who administered the medication _____

Witness _____

What form of restraint was used (if any) and any consequences: _____

Signatures **after administered**:

Staff member who administered _____ Date _____

Witnesses _____ Date _____

Parent/carer acknowledgement _____ Date _____

Comments: