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| **Child and Parent/Carer Details** | | | | | | | | | | | | | | | | | | | |
| **Child’s First and Last Name:** | | | |  | | | | | | | | | **Class name:** | | | |  | | |
| **Date of Birth (DOB):** | | | |  | | | | | | | | | **Child’s Known Allergies:** | | | |  | | |
| **Parent/Carer First and Last Name:** | | | |  | | | | | | | | | **Contact phone number for today:** | | | |  | | |
| **Parent/Carer to fill in details in this section** | | | | | | | | | | | | | | | | | | | |
| **Medication Details** | | | | | | | | | **Last Dosage Given** | | | | | **Administration for Today** | | | | Name of staff member who discussed and checked parent instructions | **I give permission for the use of this medication for my child as detailed and discussed this with my child’s teacher.**  **Parent/Carer signature:** |
| **No.** | **Date**  **DD/MM/YY** | **Name of Medication**  Eg Amoxilcillin | | **Expiry Date**  **MM/YY** | | **Reason for Use**  Eg Respiratory Tract Infection | | | **Date** | **Time** | **Dose and how it was administered**  Eg orally with food | | | **Time of next dose at**  **school** | **Dose and administration instructions**  Eg orally 1 hour before lunch with water | | |
| **1.** |  |  | |  | |  | | |  |  |  | | |  |  | | |  |  |
| **2.** |  |  | |  | |  | | |  |  |  | | |  |  | | |  |  |
| **3.** |  |  | |  | |  | | |  |  |  | | |  |  | | |  |  |
| **4.** |  |  | |  | |  | | |  |  |  | | |  |  | | |  |  |
| Additional Parent/Carer instructions: | | | |  | | | | | | | | | | | | | | | |
| **1st staff member to record details. 2nd staff member to confirm all details and witness administration. Parent/Carer to view administration record and sign at the end of the session. Store in child’s student file.** | | | | | | | | | | | | | | | | | | | |
| **□Medication’s original label/container checked** | | | | | | | |  | | | | | | |  | | | | |
| **No.** | **Name of Medication** | | **Date Given** | | **Time Given** | | **Dose and administration manner** | | **1st Educator’s Name** | | | **Signature** | | | **2nd Educator’s Name** | **Signature** | | | |
| **1** |  | |  | |  | |  | |  | | |  | | |  |  | | | |
| **2** |  | |  | |  | |  | |  | | |  | | |  |  | | | |
| **3** |  | |  | |  | |  | |  | | |  | | |  |  | | | |
| **No** | **Name of Medication** | | **Date Given** | | **Time Given** | | **Dose and administration manner** | | **1st Educator’s Name** | | | **Signature** | | | **2nd Educator’s Name** | **Signature** | | | |
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