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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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