Holy Cross Pre-school Nursery

Long term Medication form

Medication MUST be in the original containers as dispensed by the pharmacy with the child's name, DOB, dose and date. Please supply a measured medicine spoon/syringe. The medication provided must be prescribed for the reasons stated below.

Child's name:		DOB:		Date:	
Name of medicine (As recorded on container)		Dosage	Time	End date of course	
Name of medicine (As recorded on container)		Dosage	Time	End date of course	
Name of medicine (As recorded on container)		Dosage	Time	End date of course	
Reason for medication:					
Review date for long term medication:					
Additional information:					
GP's name and telephone number:					
Daytime phone number of parent or appointed adult:					

Dose History: I confirm that my child had at least a full 24-hour cycle of medication dose and has suffered no unwanted side effects from the above medication(s).

Parent Declaration: The above information is accurate at the time of writing and I give consent to the nursery staff to administer the medication in accordance with the nursery policy.

Long Term medicines: I will inform nursery immediately, in writing, if there is any change to dosage or frequency of medications.

Name of parent:		Signature:		Date:	
Staff member:		Signature:		Date:	

Name:	D.O.B:	Long Term Medication Form			
Medicine record - Administration					
Time given	**Dose**	**Name of staff administering**	**Witness**	**Parent's signature**	**Date**