Appendix A

MEDICATION CONSENT FORM

Child's Full Name	
Child's Address	
Date of Birth	
Details of Medical Condition i.e. what is the medicine for	
Name of Medicine	
Name and contact details of prescriber:	
Dosage of Medicine	
Route for administration of medicine (circle one)	Oral (by mouth) Topical (rub in) Inhale Injection Rectal
Effective from: Effective to:	Date: Date:

Any other information e.g. side effects, potential adverse reaction or special precautions	
How the medication is to be stored (as on directions given on medication label)	
Signature of Parent	
Printed name of Patent	
Date:	

Appendix B

Staff members are required to record medication administered as follows:

MEDICATION ADMINISTRATION RECORD

** Each time medication is to be administered, you must first:

- Confirm the child's identity
- Check that parents/guardians written consent has been given
- Check when medication was last given
- Check the adminstration instructions, including the name of the medication, the method and times for adminstration and the required dose
- Check whether medication is within date

Child's name: ______________________________

Date	Time	Name of Medication	Dose Given	Route of administration	Signature of person adminintering	Signature of Witness	Comments

Outcome Record

(for temperature rechecks/wheter tolerated/adverse or allergic reactions, or other)

Full Name of Child: ________________________________

Date	Time	Comment	Any action taken	Signature of Person