|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of birth |  |
| Room/age group |  |
| Reason for medication |  |
| Prescribed by |  |
| Name of medication (including brand if non-prescription) |  |
| Exact dosage required (checked against instructions on medication)  |  |
| Any specific requirements (e.g. before/after food, known side effects) |  |
| Prior parental permission |  |
| Date of medication required (or dates if multiple) |
| Mon | Tues | Wed | Thurs | Fri |
| Time(s) of medication required |
| Mon | Tues | Wed | Thurs | Fri |
| Time (and date) of last dose |
| Mon | Tues | Wed | Thurs | Fri |
| Given by |
| Mon | Tues | Wed | Thurs | Fri |
| Witnessed by  |
| Mon | Tues | Wed | Thurs | Fri |
| Parental signature  |
| Mon | Tues | Wed | Thurs | Fri |
| Times given (attach separate numbered sheet and if long-term medication required) |  |