Short Term Medication Form

|  |  |  |
| --- | --- | --- |
| ***Element 2.1.1 Each child’s health needs are supported*** | DATE: |  |

.

**NOTE: ADMINISTRATION OF ANTIBIOTICS : Children must have started the course at least 24 hours prior to attending**

**OVER THE COUNTER : We will only give these medications for a maximum period of 2 consecutive days without a letter from the doctor.**

|  |  |
| --- | --- |
| CHILD'S FULL NAME (MUST APPEAR AS ON MEDICATION): |  |
| NAME OF MEDICATION(AS SHOWN ON PACKAGING): |  |
| PRESCRIBED DOSE: |  |
| METHOD OF DOSE: (SPACER, TABLET ETC) |  |

|  |  |
| --- | --- |
| DATE MEDICATION WAS PREPARED | USE-BY DATE OF MEDICATION |
|  |  |

**Reason for medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Does your child take medication** ( ) Easily ( ) Defensively ( ) Others, pls specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| MEDICATION CHECK |
| ☐ Original Packaging/Container | ☐ Original Label | ☐ Child’s Name Clearly On Label |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE MEDICATION WAS LAST ADMINISTERED | TIME MEDICATION WAS LAST ADMINISTERED | DOSAGE ADMINISTERED | PERSON WHO LAST ADMINISTERED THE MEDICATION | TIME MEDICATION IS TO BE ADMINISTERED AT THE SERVICE |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Administration Instructions**: ( ) Before Food ( )After Food ( ) Others, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| PARENT NAME: |  | PARENT SIGNATURE: |  |
| STAFF NAME: |  | STAFF SIGNATURE: |  |