Spinney Pre-School Medication Permission Slip

Request for Spinney Pre School staff to administer prescribed medication.

Child's name: _____

Today's date: _____/_____/_____ Child's date of birth: _____/_____/_____

Named medication_____

Date of medication (from tube, box, bottle): _____/_____/_____

Expiry date of medication: _____/_____/_____

Details of illness/need for medication: _____

Name of prescribing Doctor: _____

Time(s) medication to be given each time (dosage): _____

Amount to be given each time (dosage): _____

Possible side effects: _____

_____

If the medication is an "as and when" needed medicine or is a cream please state the details of exactly when and
where to be applied or administered: _____

I, _____ (Parent/Carer) of _____

give permission for staff at Spinney Pre School to administer the above prescribed medication according to the guidelines given above. I understand that the staff **are not** responsible for any reactions or complications resulting from the administration of prescribed medication according to the directions.

I have read and understood that Spinney Pre Schools medication policy.

Signed: _____ (Parent/Carer) name: _____

Date: _____/_____/_____.