**Administration of Medicine**

Child’s name: ………………………………………. D.O.B: / /

Name of medication: ………………………………………………………….……..

Form of medication: 🞎 Tablet 🞎 Liquid 🞎 Inhaler 🞎 Spray

 🞎 Cream 🞎 Epi Pen 🞎 Other: …………………..….

Medicine expiry date: ………………… Self-administer: 🞎 Yes 🞎 No

|  |  |  |
| --- | --- | --- |
| Reactions/Symptoms/When To Administer | Time | Dosage (unit) |
|  | : |  |
|  | : |  |
|  | : |  |
|  | : |  |
|  | : |  |

Parent/Carer name: ……………………...…………………………………….

I give my permission for Oxford Active staff to administer/allow my child to administer medication as detailed above.

Signed…………………………………………………… Date: / /

**Administration Log**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Staff member | Why administered | Time | Dose | Parent Signed |
|  |  |  | : |  |  |
|  |  |  | : |  |  |
|  |  |  | : |  |  |
|  |  |  | : |  |  |
|  |  |  | : |  |  |
|  |  |  | : |  |  |