MEDICINE AUTHORISATION FORM

TO BE COMPLETED EACH DAY A CHILD NEEDS TO BE ADMINISTERED MEDICINE

- **Please note the medicine must be in the original bottle with the child's name and dosage instructions on it.**

I give my full permission for my child …….. (full name)

to be administered …… (quantity i.e. 5 mls) of ……..…….. (name of medicine)

at the following times of day: …… by a member of the Nursery Staff.

Reason for medication (i.e. ear infection) ……

Previous dosages given during the last 24 hours:

amount …….. time administered ……..

amount …….. time administered ……..

amount …….. time administered ……..

amount …….. time administered ……..

Signed ……..…… Date ……..