MANAGEMENT OF MEDICATION FORM

Name of Child: ……………………………………………………………………

Name of Staff: ……………………………………………………………………

Name of Medication: ……………………………………………………………………

Dosage: ……………………………………………………………………

Frequency of Dosage: ………………………………………………………………

Symptoms: ……………………………………………………………………

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Don't wait **ACT PROMPTLY**

Method of Administering Medication:

Storage of Medication: as per medication instructions
Out of reach of children
All staff to be aware of location

Signed: ……………………………………………………………………

Date: ……………………………………………………………………

Medical Contact: ……………………………………………………………………