Twilight Hours After School Club

Permission to administer medicine form

Child's Name	**Date of birth:**
Reason for medicine:	
Name of medicine	**Storage requirements:**
Dosage:	
Times to be administered:	
Reason for medicine:	
Name of medicine	**Storage requirements:**
Dosage:	
Times to be administered:	

I give permission for medicine to be given to my child in accordance with the details above.

Parent's signature: _____

Parent's name: _____

Date: _____

- Staff at the Out of School Club will only be permitted to administer medication to your child if you complete and return this form.
- Under no circumstances will members of staff administer medication against the will of a child.

If you have any concerns/queries, please contact Debbie or Katherine.

This policy was adopted by: Twilight Hours ASC	Date:	Policy No: PAMF 001
To be reviewed:	Signed:	
Policy Name: Permission to administer medicine form	Signed:	