Busikids Ltd

MEDICATION AUTHORISATION Date: _____

Date from: _____ Date to: _____
(For courses of medication only, not calpol, teething gel etc.)

Child's Name: _____

Child's Date of Birth _____

Parent/Carer's Name: _____

Name of Medication: _____

Dosage and/or instructions of application:

Amount _____

Time(s) _____

What time was last dose given – all medications _____
(In 24 hours)

Reason for medication _____

* I, the parent/main carer of the child named above, give my permission for the medication (named above) to be given at the stated times

* I state that the medication (named above) was prescribed by the child's G.P.

Signed _____ Date _____

* **Please delete as appropriate**

Medication Administration Record

Date	Time	Dose	Administered by	Witnessed By	Parent Signature

Date	Time	Dose	Administered by	Witnessed by	Parent signature

Date	Time	Dose	Administered by	Witnessed by	Parent signature