



## Houston EL&CC

### Administration of Medication: Short term medication

Name of Child:			
Date of Birth:			
Name of Medication:		Strength of Medication: (mg/ml)	
Type of Medication: (Liquid or tablet)		Dosage:	
Expiry Date:		Times required:	
Date(s) medication is required:		Required to be stored in fridge:	Yes/ No
Has the first dose been given?	Yes / No	Date and time given:	
Name of GP:			
Address:			
Telephone Number:			

I confirm that I consent to my child (name) \_\_\_\_\_ having the above medication at the stated times.

I confirm that I am aware that if my child becomes upset and refuses the medication that staff cannot continue with administering it. Should this happen, we would notify you via phone call.

Print Name:	
Signature:	
Date:	

Checked by staff member:	Yes/ No
Staff Signature:	
Date & time:	