

## **Administration of Medicine**

Child's name: D.O.B: / /			
Name of medication:			
Form of medication:   Tablet Liquid Inhaler Spray  Cream Epi Pen Other:			
Medicine expiry date: Self-administer: ☐ Yes ☐ No			
Reactions/Symptoms/When To Administ	ter	Time	Dosage (unit)
		:	
		:	
		:	
		:	
		:	
Parent/Carer name:			
I give my permission for Oxford Active staff to administer/allow my child to administer medication as detailed above.			
Signed			
Administration Log			
Date Staff member Why administered	Time	Dose	Parent Signed
	•		
	•		
	•		
	•		
	:		