



**Care Activities Inc – Medication Form**

Child name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Name of medication	Medication expiry date	Circumstances for medication	Dosage required / time required	Method for administration

Storage recommendation \_\_\_\_\_

**Consent to administer medication**

In consideration of the members of staff administering medication to my child (name) \_\_\_\_\_ as requested by me. I (parent/carers name) \_\_\_\_\_ indemnify and keep indemnified Care Activities, its servants and against all actions, suits, claims, demands, proceedings, losses, damages, compensation, costs, charges, and any expenses whatsoever in respect of any personal injury or infringements, disturbances or destruction of any rights of any person including myself and my child arising directly or indirectly out of the aforementioned medication.

Name of parent / carer: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of witness: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Last administered time / date	Date / time of administering	Dosage administered	<input type="checkbox"/> Child's identity checked <input type="checkbox"/> Expiry checked	Name and signature of person administering medication	Name and signature of witness

Child's name : \_\_\_\_\_

Date of birth: \_\_\_\_\_

Last administered time / date	Date / time of administering	Dosage administered	<input type="checkbox"/> Child's identity checked <input type="checkbox"/> Expiry checked	Name and signature of person administering medication	Name and signature of witness
Last administered time / date	Date / time of administering	Dosage administered	<input type="checkbox"/> Child's identity checked <input type="checkbox"/> Expiry checked	Name and signature of person administering medication	Name and signature of witness
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