Medicine Form

Child's Name: _____

Address: _____

_____ Postcode: _____

Home Tel: _____ Mobile: _____

1st Emergency Contact: _____

2nd Emergency Contact: _____

GP Name & Tel: _____

Medication

Medication Name: _____

Dose/Amount: _____

Times to be administered: _____

How is medicine to be given? (spoon, syringe etc) _____

Permission to administer medication:

I give permission for Creative Journeys for Kids staff to administer the medication detailed above, in the manner stated and to the child indicated above. Please sign below:

Print: _____ Signature: _____

Dates that you would like the medication to be administered: _____

_____

_____

_____

Adminstration Record on reverse should be completed by the member of staff who administers medication and should be witnessed by another staff member.

Creative Journeys for Kids, 18 Gillingwood Rd, Clifton Moor, York, YO30 4ST
Email: info@creativejourneysforkids.co.uk - Website: www.creativejourneysforkids.co.uk

Medicine Administration Record

Date	Time	Administered by Print/Signature	Witnessed by Print & Signature	Parent/Guardian Print/Signature

Creative Journeys for Kids, 18 Gillingwood Rd, Clifton Moor, York, YO30 4ST
Email: info@creativejourneysforkids.co.uk - Website: www.creativejourneysforkids.co.uk