Permission to Administer Prescribed Medication

Full name of child _____

Date: _____

Diagnosis of medical condition_____

Name of medication ie: Antibiotic _____

Prescribed dosage ie: 5 10ml_____

Times of dosage ie: every 2 hours _____

Start date _____

Finish date _____

I confirm I give permission for medication and/or emergency treatment to be given to my child as detailed below

Signature of parent: _____

Date: _____

N.B
It is the parent's responsibility to inform the childminder if and when treatment is no longer required.

Confirmation that medication/treatment has been received

Date:	Time Given	Childminder's Initials	Parent's Initials