## QUEENS PARK MONTESSORI DAY NURSERY 155 RICHMOND PARK ROAD, BOURNEMOUTH

## **ON-GOING MEDICATION FORM**

Name of child				Da	ite of birth			
Name of medication								
Reasons for medication								
Statement: Laive non								
Statement: I give per		-	_					
required, or at these s	stated times	:						
I understand that it is	my respons	sibility to ad	vise the nur	rsery if I hav	e given		a dose of	f the above
medication before atte	ending nurs	ery therefor	re avoiding	any chance	of an over	dose.		
Name of parent Signature of parent								
Medicine seen and ch	necked by s	taff:						
Name of staff membe	r			Signature	e of staff me	ember		
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Times given:								
Quantity:								
Administered by:								
Level 3 witness:								
Signature of parent:								

	Date:							
Times given:								
Quantity:								
Administered by:								
Level 3 witness:								
Signature of parent:								

	Date:							
Times given:								
Quantity:								
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