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## **Permission to administer medicine form**

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| **Child’s name:** | **Date of birth:** |
| **Child’s address:**  **Parent’s contact no:** | |
| **Doctor’s name:** | **Telephone no:** |
| **Address of surgery:** | |
| **Reason for medicine:** | |
| **Name of medicine:** | **Storage requirements:** |
| **Dosage:** | |
| **Times to be administered:** | |

I give permission for medicine to be given to my child in accordance with the details above.

Parent’s signature:

Parent’s name:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Staff at PLAYtarium will only be permitted to administer medication to your child if you complete and return this form.
* Under no circumstances will members of staff administer medication against the will of a child.
* Note that we can only administer medication **if prescribed by a doctor.**

If you have any concerns or questions, please contact PLAYtarium manager.