PLEASE CLICK THIS ICON TO COMPLETE THE FORM 

Medication Form

(One medication per form)

Child's first name:		**Child's surname:**	
Date of birth:		**Date form completed:**	
Parent/ carer full name:		**Parent/ carer contact number:**	

Declaration	**I _____ (parent/ carer) give qualified staff at Little Jungle permission to administer the medication stated below to my child**

Name of child's condition/ illness:		**Time(s) to be administered at Little Jungle:**	
Medication Name/Type:		**Dosage required:**	
If prescribed, who by:	☐ Pharmacist ☐ Doctor ☐ Nurse ☐ Dentist	**If not-prescribed, parent initials:**	
Has the label on the medication been cross checked against the information on this form	☐ Yes ☐ No	**Period medicine is required to be taken (dates):**	From: To:

Team Manager name:	**Team Manager signature:**	**Parent / carer name:**	**Parent / carer signature:**

Medication administration:

47a Amott Road, London, SE15 4HU | Tel: 020 7277 7171

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Date	Time	Dosage	Staff (print name & sign)	Witness (print name & sign)	Parent/ Carer (print name & sign)

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