



Long Term Medication Form

Child's Name: _____

I give permission for: _____ to administer specific medication to my child.

Name of Medication: _____

Reason for Medication: _____

Dosage: _____ Frequency: _____

Start Date: _____ Signed: _____ Parent/Guardian

Date	Date/time parent last administered treatment	Parent initial as confirmation of last treatment	Time given in setting	Dosage given	Childminders initial when administered	Parent to sign after confirming medicine/ treatment given

Note: It is the parent or guardian's responsibility to inform the Tithe Barn Staff if and when treatment is no longer required.