Individual Health Plan / On going Medication Form

Date of completion: _____

Child's Full Name: _____

Name of Medication: _____

In what circumstances/situations should this medicine be given:

Dosage/Method for administering medication:

Parent Signature _____

If medicine is required during care – staff are to record details below

Date	Reason required	Dosage	Time Given	Qualified Staff Signature	Signed Parental acknowledgement