

Medicines Form



Part 1 – Parent to complete

Date: _____

Child's Name: _____ Child's DOB: ____/____/____

Start of Prescription		End of Prescription	
Name & type of Medication		Reason for administering this medication	
Dosage		Method of administration**	
Times to be given in the day*		Anything else to note	
Prescribing Doctors Name		Prescribing Doctors Tel. Number	

*Please note that we can only administer any medications during the opening times of either Club.

** We are not able to force any child to take any medications. I hereby consent to the delegated member of Staff of the Apex Club to administer the above medication according to the above instructions.

Signature of Parent / Carer Date

Apex 360 Ltd

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Email: office@apex360.co.uk

Web: www.apex360.co.uk

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 Hemel Hempstead, Hertfordshire, HP2 7DT
 Reg Co: 08003244 VAT: 131541746

Medicines Form

Print name:

Part 2 – Apex staff to complete

Date _____

Important checking points for Staff:

- Carefully read the instruction details overleaf
- Check the child’s details to ensure the right child – Name & DOB
- Check that the medication label for right child, right drug, in date, right dose, right route and right date & time
- Two members of Staff to witness all administering & initial this form after administration
- Ensure the medication is stored safely & correctly

Date & Time	Dosage	Administered by	Witnessed by	Parents/Carers Signature*

* Parents/Carers you are signing to say that you have been informed when & what medications have been administered to your child.

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