



(Office use only)

GL:

Holiday code:

Group No:

Parental Agreement for PGL Staff to Administer Medication

PGL will not give your child medication unless you complete and sign this form.

Name of Child:

Booking Reference:

Age Group:

Date of Birth (DD/MM/YYYY) :

Name of Medication: (as described on the container)		Date Dispersed:		Expiry Date:			
Reason for taking Medication:				Has your child had this medication before?		Y/N	
Dosage & Method of Administration:		Time to be Given: (please circle)	Breakfast (please add a time before/after if required)	Lunch (please add a time before/after if required)	Dinner (please add a time before/after if required)	Bed Time (please add a time before if required)	Other Times (please add times)
			Before Food	Before Food	Before Food		
			After Food	After Food	After Food		
Special Precautions:				With Food	With Food	With Food	
Are there any Side Effects we should know about:				With Food	With Food	With Food	
Procedures to take in Emergency:					Can your child self medicate?		Y / N

Name of Medication: (as described on the container)		Date Dispersed:		Expiry Date:			
Reason for taking Medication:				Has your child had this medication before?		Y/N	
Dosage & Method of Administration:		Time to be Given: (please circle)	Breakfast (please add a time before/after if required)	Lunch (please add a time before/after if required)	Dinner (please add a time before/after if required)	Bed Time (please add a time before if required)	Other Times (please add times)
			Before Food	Before Food	Before Food		
			After Food	After Food	After Food		
Special Precautions:				With Food	With Food	With Food	
Are there any Side Effects we should know about:				With Food	With Food	With Food	
Procedures to take in Emergency:					Can your child self medicate?		Y / N

Name of Medication: (as described on the container)		Date Dispersed:		Expiry Date:			
Reason for taking Medication:				Has your child had this medication before?		Y/N	
Dosage & Method of Administration:		Time to be Given: (please circle)	Breakfast (please add a time before/after if required)	Lunch (please add a time before/after if required)	Dinner (please add a time before/after if required)	Bed Time (please add a time before if required)	Other Times (please add times)
			Before Food	Before Food	Before Food		
			After Food	After Food	After Food		
Special Precautions:				With Food	With Food	With Food	
Are there any Side Effects we should know about:				With Food	With Food	With Food	
Procedures to take in Emergency:					Can your child self medicate?		Y / N

Name:

Signature:

Date:

Relationship to Child: