## Care Plan for continued use of medicines administered to children

Date

It is agreed that (*name of child*) Date of birth

will receive *(name of medication)*

Dosage

every day am pm *(times to be administered)*

any additional times needed

Reason for medication

List of triggers *(e.g. change of temperature/allergies/nuts)*

What do we need to do if there is a reaction

This arrangement will be reviewed at the end of this term or if parent advices of any changes

Review date \_\_\_\_\_\_\_\_\_\_\_\_

I understand that I must deliver the medication personally to the Management Team.

*Parent/guardian telephone contact details*

*Parent/guardian with legal responsibility* (signed )

 (printed)

*Manager/Deputy* (signed) Date