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**REQUEST FOR SET YOUR SIGHTS TO ADMINISTER MEDICATION**

Dear Set Your Sights,

I request the administration of medicine to :

**Childs Details**

Surname………………………………………….

First Name.................................

Male/Female……………….

Date of Birth..........................

Address......................................................................................................

...................................................................................................................

Condition or illness…………………………………………………………

**Medication**

Name/Type of Medication (See container)................................................

For how long will this medicine be administered?............................................................

Date Dispensed........................................................................................

The above medication(s) have been/have not been\* prescribed by a doctor. They are clearly labelled indicating contents, dosage and child’s name in full.

\*please delete as appropriate

Name of Prescribing Doctor...................................................................

Address of Prescribing Doctor…………………………………………………………………

Directions for Use

Dosage and Method..............................................................................

Times of Administration………………………………………………………………

Any special precautions ........................................................................................

Any possible side effects..........................................................................

Is supervised self administration possible............................................................

Emergency Contact Details

Name .................................................................

Daytime Telephone Number....................................................................

Mobile Telephone Number.........................................................

Relationship to child............................................................................... Address...................................................................................................................... ............

Postcode .......................................

I understand that the medicine must be provided and that Set Your Sights will only be able to administer the medicines if all the above information is completed satisfactorily. I understand that I remain responsible for ensuring that my child receives administration if Set Your Sights is unable to.

Signed……………………................................……………………………

Address (if different from child address) :

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Date................................