MEDICATION REPORT

Name: _____

DATE	MEDICINE NAME	DOSAGE/TIME	PARENT SIGNATURE	GIVEN BY

During the year there will be times when we will be cooking, experiencing food from different cultures and celebrating birthdays.

Please complete the section below if your child has specific dietary requirements.

My child is unable to eat the following foods:

_____

_____

_____

_____

Reasons: (please tick) ☐ Dietary ☐ Cultural ☐ Allergy/Medical

Parent Signature: _____