

Medication Authority and Administration Form

MEDICATION AUTHORITY – to be completed by the parent/guardian

Child's Name: Date of birth:

Name of Medication: Expiry date:

Dosage of Medication: Method of Administration:

Additional instructions (e.g. to be refrigerated):

Time and date the medication was last administered to your child Date: Time:

Time and date (or the circumstances under which) the medication should next be administered
Date: Time: or Circumstances:

Administer for 2 or more consecutive attendance days (e.g. antibiotics)
Start date: Finish date:

DETAILS OF ADMINISTRATION

Dosage: Method Time to be administered:

Please circle: Before food / with food / after food

Can the Child Self-Administer YES / NO

Prescribing Doctor's Name: Phone no:

Letter from Doctor/Medical Management Plan provided? NO YES

I,(parent or person named in enrolment form), give authorisation for the medication(s) listed above to be administered by the service, as described.

I acknowledge the service can only administer medication from its original container, bearing the original label and instructions, and within the expiry/used by date printed on the container/label. Where the medication is a prescribed medication, the label must have the name of the child whom the medication is to be given.

I recognise medication will only be administered by the services in accordance with the instructions attached to the medication or otherwise instructed by a registered medical practitioner.

Parent/guardian name: Phone no:

Signature: date:

Staff member receiving medication:

Signature: date: