

# MEDICATION AUTHORITY & ADMINISTERING FORM

## MEDICATION AUTHORITY – to be completed by the parent/guardian

Childs Name: ..... Date of birth: .....

Name of medication: ..... Expiry date: .....

Reason for medication: .....

Medication storage instructions (e.g. to be refrigerated): .....

Please indicate how long this medication needs to be administered:

Today only – todays date: .....

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

Ongoing, regular medication (e.g. Ventolin) - Start date: .....

## DETAILS OF ADMINISTRATION

Staff will only be able to administer medication if it is received in the original packaging, with a chemist label attached stating the child's name and dosage. All medication is administered under adult supervision.

**My child can self-administer his/her own medication?** YES NO

**Medication to be administered:** Dosage: ..... Time: .....  
Method :.....

**Circumstances of administration:**  
Please circle: Before food / with food / after food

**Prescribing Doctor's Name:** ..... **Phone no:** .....

Letter from doctor/medical management plan provided? NO YES

Parent/guardian name: ..... Phone no: .....

Signature: ..... Date: .....

Educator receiving medication: .....

Signature: ..... Date: .....

Coordinator signature: ..... Date: .....

## MEDICATION ADMINISTERING

