Administration of Authorised Medication Record

Nominated Supervisor's Name: Dina Liberow	Date:
Nominated Supervisor's Signature:	
Parent's Name(s):	Date:
Parent's Signature(s):	

Child's full name _____

Medication/Dosage: _____

FORM DECLARATION

By signing this Administration of Medication Record, I declare that this Record has been completed taking into account the child's Medical Management Plan, Medical Conditions Risk Minimisation Plan, the advice of parents and the child's medical practitioner. Details of any instructions for the medication are attached.

Name of Person Completing Form _____

Signature of Person Completing Form _____

Date Form Completed _____

AUTHORISED CONSENT

The individual, or individuals, listed below consent to the administration and/or self-administration of medication to their child listed on the Administration of Medication Record below.

Parent's Full Name _____

Parent's Signature _____

Date of Signature _____ _____

OR

Authorised Person Must be listed on the child's Enrolment Form

Authorised Person's Full Name _____
Authorised Person's Signature _____
Date of Signature _____

Administration of Authorised Medication by the Service

Separate form required for each medication.

Child's full name _____

Full of Name of Medication	Expiry or Use-By Date	Circumstances for Administration	Dosage Required	Administration Instructions

Any Additional Instructions (if necessary)

Storage Instructions including Location of Storage
Place in First Aid Cabinet

Time and Date Medication Last Administered At Service	Time and Date Medication Administered	Dosage Administered	Name and Signature of person who Administered the Medication	Time and Date (or the circumstances under which) Medication to be Next Administered At Service

Name and Signature of Witness	Time and Date Process Witnessed	Was the Identity of the Child Checked	Was the Dosage of the Medication Checked
		○ Yes ○ No	○ Yes ○ No