IOSHC
INDOOROOPILLY OUTSIDE SCHOOL HOURS CARE

MEDICATION AUTHORITY AND 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? _____

Medication to be administered: Dosage: _____ Time: _____

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

Prescribing Doctor's Name: _____ **Phone no:** ……

Letter from doctor/medical management plan provided? _____

Parent/guardian name: …… **Phone no:** ……

Signature: …… **Date:** ……..

Educator receiving medication: ……

Signature: …….. **Date:** ……..

Coordinator signature: ……

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MEDICATION ADMINISTERING							
LAST ADMINISTERED		TODAYS DATE	TIME GIVEN	DOSAGE & METHOD OF ADMINISTRATION Before/With/After food	EDUCATOR	WITNESS	PARENT/ GUARDIAN SIGNATURE AND DATE
Date	Time				Name and Signature	Name and Signature	