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: _____ **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: _____

☐ Emergency response medication (e.g. Epipen) - todays 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.
If the child received medication before attending the service the parent must provide the date, time and dosage medication was administered to management. Parents must sign the Medication Administration form at collection on the days medication was administered.

My child can self-administer his/her own medication? _____

Medication to be administered: Dosage: _____ Time: _____

Circumstances of administration:
Please indicate: ☐ Before food ☐ with food ☐ after food ☐ As needed

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

Letter from doctor/medical management plan provided? _____

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

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

Manager receiving medication: .....

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

Coordinator signature: .....

MEDICATION ADMINISTERING

LAST ADMINISTERED		TODAYS DATE	TIME GIVEN	NAME OF MEDICATION	DOSAGE	METHOD OF ADMINISTRATION e.g. Oral Before/With/After food	EDUCATOR	WITNESS	PARENT/ GUARDIAN SIGNATURE AND DATE
DATE	TIME						NAME AND SIGNATURE	NAME AND SIGNATURE	