Medication Form

THIS SECTION TO BE COMPLETED BY THE PARENT/AUTHORISED PERSONS

Child's Name: _____ Date for Medication to be given: ____ / ____ / ____

Please circle your child's class group: Koala / Platypus / Kookaburra / Possum / Wombat

Medication Administration Description

Full Name of Medication: _____

Dosage Amount to be given: _____ Expiry Date Checked: ☐

Reason for Medication to be given: _____

Medication Storage Requirements

☐ Refrigerated (locked container) ☐ Non Refrigerated (locked container/cabinet)

Dosage Method

Dosage Method: ☐ Orally ☐ Topical Cream/Ointments (non- prescription) ☐ Teething Gel

☐ Other If other, please specify: _____

Medication Administration Directions – *Ensure exact times are provided*

Time medication to be administered: *1st dose*: _____ am / pm; *2nd dose*: _____am / pm

Notes *(eg. With food)*: _____

Date of Last Dosage given at home: ____ / ____ / ____ Time of Last Dosage at home: _____ am / pm

For Topical Creams/Ointment (non-prescription) only:

Please specify the frequency to be applied: (*eg: after each nappy change*)

_____

Written Authorisation by Parent/Authorised Persons

I agree to the administration of the above medication by an approved member of staff, and I confirm that the medication is for the above named child and that the dosage and time to be given is correct.

Parent/Authorised Persons Signature: _____Date:____/_____/____
(As per the Enrolment Form)

THIS SECTION TO BE COMPLETED BY THE EDUCATOR ADMINISTERING MEDICATION

Child's name: _____ Date for Medication to be given: ____ / ____ /_____

Full Name of Medication: _____ Expiry Date Checked: ☐

Cross Checking Medication to be administered against the Label

Label on medication cross checked against *Medication Administration Description* provided by parent: ☐

Dosage Method

Dosage Method: ☐ Orally ☐ Topical Cream/Ointments (non- prescription) ☐ Teething Gel

☐ Other If other, please specify: _____

Record of Educator who Administered Medication - 1st Dose

Time administered: _____am / pm Dosage Amount given: _____

Administered By

Name: _____Signature: _____

Witnessed By

Name: _____Signature: _____

Comments: _____

Record of Educator who Administered Medication - 2nd Dose

Time administered: _____am / pm Dosage Amount given: _____

Administered By

Name: _____Signature: _____

Witnessed By

Name: _____Signature: _____

Comments: _____