OOSH Northern Beaches
Administration of Authorised Medication Record

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

Child's full name _____

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. Medication must be administered following any instructions outlined on the medication as well as any written or verbal instructions from the child's registered medical

Name of Person Completing Form _____

Signature of Person Completing Form _____

Time and Date Form Completed _____

AUTHORISED CONSENT

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

Parent's Full Name _____

Parent's Signature _____

Time and Date of Signature _____

OR

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

Authorised Person's Full Name _____

Authorised Person's Signature _____

Time and 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**
Original Container Original Label Child's Name Clearly on Label				

Any Additional Instructions (if necessary)

Storage Instructions including Location of Storage