OOSH NORTHERN BEACHES Centre: _____

Administration of Medication Record

Authorisation of Consent

By signing this *Administration of Medication Record*, I give permission for educators to administer the prescribed medication in accordance with the *Administration of Medication Policy and procedure*. I declare that this Record has been completed in conjunction with the child's Medical Management Plan, if applicable.

- Please understand that medication will only be administered as directed by the medical practitioner and only to the child whom the medication has been prescribed for. Expired medications will not be administered.
- Medication MUST be in the original container with the dispensing label attached
- A separate form must be completed for each medication if more than one is required

Administration of medication: I give permission for my child to self-administer medication in accordance to the *Administration of Medication Policy and Procedure*. I understand educators will supervise and witness self-administration of medication and complete the following record.

(See Enrolment Form for detailed authorisation to administer medication or self-administer medication R. 96. Authorisation must be provided by a parent or a person named in the child's enrolment record as authorised to consent to administration of medication.)

Child's full name *(must appear as on medication)*	
Date of birth	

Administration of medication form is valid from	/ /	TO	/ /
Parent/guardian signature			
Date			

MEDICATION DETAILS

Name of medication *(as shown on packaging)*	
Medical practitioner prescribing medication	
Expiry date /Use by date	
Reason for medication to be administered	
Storage instructions for medication	

Administration of Medication details

Child's name …… Date of birth ……..

Parent to complete								
Medication **last** administered		Medication **to be** administered		Dosage of medication to be administered	Method of administration	Parent/Carer name	Parent/Carer signature	Comments
Time	Date	Time	Date					

Educator to complete when administering medication							
Medication Administered		Dosage of medication	Method of administration	Name of person administering medication	Signature	Name of person witnessing administration	Signature
Time	Date						

Educator and parent to complete when medication has been **self-administered** by child/student over preschool age							
Medication Self-Administered		Dosage of medication	Method of administration	Name of person witnessing administration	Signature	Name of parent acknowledging self-administration	Signature
Time	Date						