Administration of Authorised Medication Record

Separate form required for each medication.

Team

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 practitioner.

Name of Educator Completing Form ____

Signature of Educator Completing Form ____

Time and Date Form Completed ____

AUTHORISED CONSENT

The individual, or individuals, listed below consent to the administration and/or self-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 ____