Medication Authority

To be completed by the PARENT/GUARDIAN
This information is confidential and will be available only to relevant staff and emergency medical personnel.

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 an Authorised Prescriber and the child's Medical Management Plan

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 to the medication not box.
- A separate form must be completed for each medication if more than one is required
- Staff do not monitor the effects of medication as they have no training to do this
- Staff are instructed to seek emergency medical assistance if concerned about a person's behavior following medication.

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

Administration of medication form is valid from	/ /	TO	/ /

MEDICATION DETAILS

Name of medication *(as shown on packaging)*	
Expiry date /Use by date	
Reason for medication to be administered	
Dosage of medication	
Time to be administered	
Method of administration	
Storage instructions for medication	

ACSIA PLAN	YES NO N/A	MODIFIED DIET PLAN	YES NO N/A

I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to supervising staff and emergency medical personnel and agree to this information being displayed

Parent / Authorised Person on Enrolment Form NAME			
Signature		Date	

Administration of Medication details

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

To Be Completed by Parent / Authorised Person in Enrolment Form								To be completed by Educator			
Medication **last** administered		Name of Medication	Medication **to be** administered		Dosage of medication to be administered	Method of administration	Parent/Authorised Person name & Signature	Medication administered		Educator Administering Name & Signature	Witness Name & Signature
Date	Time		Time	Date				Time	Dosage & Method		