



Prescribed Medication Authorisation

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|----------------|------------------------|
| Name of child: | Child's date of birth: |
|----------------|------------------------|

I.....(Parent /Guardian) authorise a trained team member holding a current 1st aid qualification to administer the following medication to my child.

Name of medication:.....
 To be administrated from:(Date) to(Date)

| | | | |
|-----------------------------------|--------------|--------------|--------------|
| Dosage of each administration: | 1)..... | 2)..... | 3)..... |
| Times of day to be administrated: | 1).....am/pm | 2).....am/pm | 3).....am/pm |

Has your child been given this medication prior to this request today Yes/No,
 If YES. Has your child shown any adverse reactions to this medication previously. Yes/No
 Have you administered including prescribed or pharmacy brought or alternative or complementary medicine in the previous 24hrs? Yes/No

Medication.....(name) was last given:.....(Date).....am/pm by.....
 Medication.....(name) was last given:.....(Date).....am/pm by.....
 Medication.....(name) was last given:.....(Date).....am/pm by.....

Special instructions:

Method of use: Cream/Oral/Tablet/Capsule/ Drops/Inhalant
Expiry Date:..... Medication storage: Refrigerated/ Non Refrigerated

.....
 Parent/Guardian Name
Staff receiving form & Medication Signature
 Medication.....(name) was last given:.....(Date).....am/pm by.....

Record of administration-

| Team member administering medication | Signature | time | dose | Team member witnessing administration of medication | Signature | Parent signature |
|--------------------------------------|-----------|------|------|---|-----------|------------------|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |