

Medication Authorisation Form

To be completed by the parent/guardian when medication is required for a medical condition which is not supported by a Medical Action Plan or if a child has a short-term illness. Supporting documentation is required from a medical practitioner.

Childs Name:			
Date of Birth:			
Medication Information			
Medical Condition:			
Medication Type:			
Medication Expiry:			
Medication Storage:	☐ Stored in Service	☐ Signed in Daily	
	☐ Refrigeration required	☐ Locked box required	
Medication Administration			
<i>Please indicate how long this medication needs to be administered:</i>			
Today Only ☐	Date:	Consecutive Days ☐	Start:
Finish:			
<i>Please indicate the specific information regarding the administration of this medication:</i>			
Last administered before OSHC/VC:	Time/Date:	By how:	
To be administered at OSHC/VC:	Time:		
Additional information or Self Administration			
Medication Support Documentation			
<i>A supporting document has been provided from a Doctor confirming that the medicine (prescription or over the counter) has been prescribed and can administered for a specified length of time</i>			
Letter for Doctor:	☐ Yes		☐ No No medication can be administered
Parent/guardians Information			
Parent/guardians understand and agree to the following information:			
☐ Children under 6 years of age will not be administered medication to treat cough and cold symptoms, in accordance with the Therapeutic Goods Administration review of the safety and efficiency of registered over-the-counter cough and cold medicines (15 August 2012).			
☐ All prescribed medications must have the original pharmacist's dispensing label, details provided by the Doctor giving the child's name, name of medication, dosage, frequency and way it is to be administered, date of dispensing and expiry date, subject to Regulation 95 of the Education and Care Services National Regulations (2012) for Western Australia, and Regulation 95 of the Education and Care Service National Regulations (2011) for all other jurisdictions.			
☐ Parents/guardians are required to alert the Coordinator of their child's medication requirement and give the medication to an Educator on arrival to the Service.			
Parent Guardian Sign Off			
Date completed: _____			
Name:		Signature:	
Coordinator Verify			
Name:		Signature:	