Administration of Authorised Medication Record	Team
Nominated Supervisor's Name:	Date:
Nominated Supervisor's Signature:	

Child's full name _____

FORM DECLARATION

By signing this Administration of Medication Record, I declare that this Record has been completed with consideration of the child's Medical Management Plan and Medical Management Risk Management Plan as well as the advice of parents and the child's medical practitioner.

Details of any instructions attached to the medication are attached together with any verbal or written instructions from the child's registered medical practitioner.

Name of Person Completing Form _____

Signature_____

Time and Date_____

AUTHORISED CONSENT

The individual, or individuals, listed below consent to the administration of medication to their child listed on the Administration of Medication Record below.

Parent's Full Name _____

Signature_____

Time and Date_____

OR

(Authorised Person Must be listed on the child's Enrolment Form)

Authorised Person's Full Name _____

Signature_____

Time and Date_____

Long Term Administration of Authorised Medication by the Service

Child's full name: _____Start Date_____ End Date_____

Full of Name of Medication	Dosage Required	Circumstances for Administration
o Expiry or Use-By Date Yes / No o Original Container Yes / No o Original Label Yes / No o Child's Name on Label Yes / No	Administration Instructions	
Storage Instructions including Location of Storage:		

Time and Date Medication Last Administered					
Time and Date Medication Administered					
Dosage Administered					
Name and Signature of person who Administered the Medication					
Time and Date (or the circumstances under which) Medication to be Next Administered					
Name and Signature of Witness					
Time and Date Process Witnessed					
Was the Identity of the Child Checked	o Yes o No	o Yes o No	o Yes o No	o Yes o No	o Yes o No
Was the Dosage of the Medication Checked	o Yes o No	o Yes o No	o Yes o No	o Yes o No	o Yes o No