MEDICATION PERMISSION FORM

Short Term Medication – 5 Days ONLY

*In the interest of children's safety and well-being, the service shall only administer medication if it is in its original container with the **dispensing label** attached listing the child as the prescribed person, strength of drug and frequency it is to be given. This applies to all medications, regardless of whether they are non- prescribed (such as cough medicines, anticeptic creams etc) or prescribed (antibiotics etc). **Pharmacies can provide dispensing labels for non-prescribed medication**.*

Service Name:	Date to Commence: / /	Date to Conclude: / /

CHILD'S FULL NAME:	Date of Birth:
Telephone No:	Mobile No:
Doctor:	Telephone No.
Specialty Provider:	Telephone No.

MEDICATION DETAILS

Name of Medication:			
Date Prescribed:		Expiry Date:	
Reason/diognosis for Medication:			
Storage requirements:			
Additional Comments: to be taken with food etc.			

I verify that the medication administration information above is correct: The medication provided is in its original container and in my child's name, I give staff permission to administer the medication as instructed in the table below. (Parent to complete highlighted section.)

Parent/guardian NAME:	Date:
Parent/guardian SIGNATURE:	

ADMINISTRATION DETAILS

Date:	Dosage:	Time to give medication	Actual time medication given	Expiry date of medication	Signature of staff administering medication	Signature of staff checking medication	Comments: