MEDICATION PERMISSION FORM

Short Term Medication – 10 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 provided 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:**	**Manner in which the medication was and is to be administered:**	**Please circle: BY MOUTH/INJECTION/APPLICATION TO SKIN**	
Parent/Guardian SIGNATURE:				

(Parent/Guardian to complete)				Catholic Early Learning and Care Nominated Supervisor/Lead Educator/Educator to complete					
Date & Time medication was last adminsitered:	Date:	Dosage:	Time to give medication:	Actual time medication given & method medication was administered	Print name of staff administering medication	Signature of staff administering medication	Print name of staff checking medication	Signature of staff checking medication	Comments: