GOSHC MEDICATION AUTHORITY

MEDICATION AUTHORITY – to be completed by the parent/guardian

Childs Name: ..... **Date of birth:** ……

Name of medication: …… **Expiry date:** ……..

Reason for medication:
……

Please indicate how long this medication needs to be administered:

☐ Today only – todays date: ……

☐ For 2 or more consecutive attendance days (e.g. antibiotics)

Start date: …….. finish date: ……

DETAILS OF ADMINISTRATION

Staff will only be able to administer medication if it is received in the original packaging, with a chemist label attached stating the child's name and dosage.

Dosage: …….. time to be administered: ……

Please circle: Before food / with food / after food

Prescribing Doctor's Name: ..... **Phone no:** ……

Letter from doctor/medical management plan provided? NO YES

Parent/guardian name: ..... **Phone no:** ……

Signature: …….. date: ……..

Staff member receiving medication:
.....

Signature: …….. date: