Administration of Medication Authority Form

By signing this Administration of Medication Form, I give permission for Educators to administer the listed medication in accordance with the pharmacy instructions. I declare that this record has been completed in conjunction with the child's Medical Management Plan/ Action Plan, if applicable.

Child's full name (must appear as on medication)		Child's Date of Birth	

Parent/Guardian name (print)		Parent/Guardian signature	
Emergency contact number		Date	

This administration of medication authority is valid (dd/mm/yyyy) FROM / / TO / /

Name of medication (as shown on container)		Expiry date/ Use by date
Name of Medical practitioner prescribing medication		Medical practitioner phone number
Days to be administered while at the Service: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	Time medication is to be administered:	Dosage of medication to be administered Medication to be administered by: ☐ Staff ☐ Child permitted to self-administer
If no prescribed date/time, circumstances when this medication should be administered:		
Is this medication administered to the child when he/she is not at OOSH Y☐ N☐ If Yes, by whom and when:		
Medication to be stored ☐ Fridge ☐ Room temperature		Medication to be administered ☐ With food ☐ Without food ☐ Either
As required by the Service Medical Conditions and Administration of Medication Policy: ☐ Medication is in its original packaging ☐ Labelled with Name of child ☐ Dosage instructions provided by the pharmacist ☐ Within a current expiry date/Use by date		Possible side effects, if any, that OOSH Educators should be aware of:

Office use only:

Name of Educator (Medical/ First Aid officer)	Educator signature	Date
Coordinator (print name)	Coordinator signature	Date
Entered in OWNA	Educator sign	Date