

Carina Heights Child Care & Development (2014)

Medication Permission and Administration Form

Child Details

Surname: _____ Given name: _____

Room: _____

Medication Details

Name of medication: _____ Chemist label : yes / no

Dosage required: _____

Method for administration: _____

Medical Practitioner / Pharmacist: _____ Doctors Letter: yes/no

Comments OR Any preferred parent contact details for today to assist staff with child's health care:

Parent / guardian's name: _____

Parent / guardian's signature: _____ Date: _____

OR If applicable Signature of person authorised to consent to medication administration.

Medication Administration Requirements (must be completed daily)

	Monday	Tuesday	Wednesday	Thursday	Friday
Date for administration					
Time last administered					
Time required					

Educator to Complete Upon Administration

Date administered					
Dosage administered					
Time administered					
Name of educator administering					
Signature of educator administering					
Name of educator witnessing					
Signature of educator witnessing					
Comments					