Medication Form

Parent/Guardian Section – To be completed by the parent or guardian

Date for Medication to be given: ____ / ____ / ____ Child's Name: _____

Parent Name: _____ Child' Grade:_____

Medication Administration Description

Full Name of Medication: _____

Please note Paracetamol and Nurofen cannot be written up for Educators to administer to a child. These products are not medications. They treat the fever and offer pain relief and mask the symptoms of the actual underlying illness. If a child requires these products throughout the day, they are not well enough to be at the Service

Dosage Amount to be given: _____ Expiry Date Checked: ☐

Reason for medication, please name medical condition associated: _____

Medication Storage Requirements

Please tick: ☐ Refrigerated (locked container) ☐ Non-Refrigerated (locked container/cabinet)

Dosage Method to be used by Educators

Dosage Method please tick: ☐ Orally; or ☐ Applied – Topical creams or ointments -If ticked please fill out the below section.

Topical Creams/Ointments

☐ Topical Cream/Ointments (non- prescription)

☐ Other - If other, please specify: _____

For Topical Creams/Ointments (only) - For longer term use of topical creams/ointments, please document start and finish date that the application needs to occur.

For topical creams/ointments please specify the frequency to be applied:

Please specify: _____

Start date: _____ Finish date: _____

Medication Administration Directions - This section must have exact times written in by the parent/guardian.

Time medication to be administered: 1st dose: _____ am / pm; 2nd dose: _____am / pm

Date of Last Dosage given at home: ____ / ____ / ____ Time of Last Dosage at home: _____ am / pm

Written Authorisation by Parent/Authorised Persons

I agree to the administration of the above medication by an approved Educator. I confirm that the medication is for the above-named child and that the dosage and time to be given is correct.

Parent/Guardian Full Name: _____

Parent/ Guardian Signature: _____

Office Use only – To be completed by the Administrator/Responsible Person (receiving medication)

Date: _____ Admin/RP name: _____

Child's name: _____

Full Name of Medication: _____ Expiry Date Checked: ☐

Dosage Method

Dosage Method please tick: ☐ Orally; or ☐ Applied – Topical creams or ointments -If ticked please fill out the below section.

☐ Topical Cream/Ointments ☐ Other - If other, please specify: _____

1st Dose: Time to administer: _____am / pm, Dosage Amount to be given: _____

Comments: _____

2nd Dose: Time to administer: _____am / pm, Dosage Amount to be given: _____

Comments: _____

☐ I have added this medication record to the Medication Register

Educator Section – To be completed by the Educator administering medication

Cross Checking Medication to be administered against the Label

Label cross checked against (Medication Administration Description) provided by parent/guardian: ☐ Yes ☐ No

Name of Educator who has cross checked medication: _____

Record of Educator Who Administered Medication - 1st Dose

Date: ___/____/____ Time: ___: ___am/pm Administered by: _____

Signature: _____

Record of Educator Who Witnessed Administration of Medication -1st Dose

Date: ___/____/____ Time: ___: ___am/pm Witnessed by: _____

Signature: _____

Record of Educator Who Administered Medication - 2nd Dose

Date: ___/____/____ Time: ___: ___am/pm Administered by: _____

Signature: _____

Record of Educator Who Witnessed Administration of Medication- 2nd Dose

Date: ___/____/____ Time: ___: ___am/pm Witnessed by: _____

Signature: _____

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