Medication Authority – to be completed by the parent/guardian				
Childs name		Date of birth		
Name of medication		Expiry date		
Reason for medication				
Medication storage instructions (e.g. to be refrigerated)				
Please indicate how long this medication needs to be administered				
☐	Today only	Today's date		
☐	2 or more consecutive attendance days (e.g.antibiotics)	Start date	Finish date	
☐	Ongoing, regular medication (e.g. Ventolin)	Start 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. All medication is administered under adult supervision.**				
My child can administer his/her own medication		☐ Yes	☐ No	
Medication to be administered		Dosage	Time	
Circumstances of administration		☐ Before Food	☐ With Food	☐ After Food
Prescribing Doctor's name			Phone number	
Letter from doctor/medical management plan provided			☐ Yes	☐ No

Medication Authority and Administering Form

Parent/guardian name	Phone number
Signature	Date
Educator receiving medication	
Signature	Date
Coordinator Name	Signature