



# Family Day Care Gympie Region



## MEDICATION AUTHORISATION FORM

Sponsored by the Uniting Church

I, \_\_\_\_\_ authorise \_\_\_\_\_

to give my child: \_\_\_\_\_ D.O.B. \_\_\_\_\_

the following medication: Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Date and Time previous dose given: \_\_\_\_\_

Times to be given: \_\_\_\_\_

Dates to be given: \_\_\_\_\_

Name of Child as stated on medication: \_\_\_\_\_

Expiry Date of medication: \_\_\_\_\_

Doctor's Name & Phone Number : \_\_\_\_\_

Medical Action Plan: \_\_\_\_\_

Sign / symptoms / circumstances under which medication should be administered: \_\_\_\_\_

Special Instructions: (i.e. after meals, before meals, etc.) \_\_\_\_\_

Method of administering the medication: \_\_\_\_\_

Self Administered by child: Yes: No: \_\_\_\_\_

Parent or Authorised Person Contacted: Yes No Contact Number: \_\_\_\_\_

Time Parent or Authorised Person Contacted: \_\_\_\_:\_\_\_\_ am: pm:

Parent or Authorised Person Signature: \_\_\_\_\_

Person who administered the medication: \_\_\_\_\_

Dosage Delivered: \_\_\_\_\_ Manner of delivery: \_\_\_\_\_

Date and Time(s) Given: \_\_\_\_\_

Educator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_