

Medical Authority Form

ourpatchgroup

A patch for every child to grow.

Medication must be in its original package with a pharmacist's label which clearly states the child's name, dosage, frequency of administration, date of dispensing and expiry date.

*** MUST BE COMPLETED**

Child's Details

* First Name		* Date of Birth	
* Last Name		* Program/School	

MEDICATION AUTHORITY – to be completed by the parent/guardian.

I authorise staff at Our Patch Outside School Hours Care to administer the following.

* Name of medication (as per chemist label)		* Expiry Date	
* Medication storage instructions DRY COOL PLACE / REFRIGERATION REQUIRED / OTHER			
* Reason for medication (e.g. asthma, allergy etc)			
* Has a current (less than 12mths) Medical Action Plan been provided	☐ YES	☐ NO	

* How long this medication needs to be administered: **(one of the below must be completed)**

☐ Today only	Date		
☐ Short term	Start Date		Finish Date
☐ Ongoing	Start Date		For long-term, regular medication e.g. Ventolin, EpiPen, Ritalin

DETAILS OF ADMINISTRATION – All medication is administered under adult supervision

* Can your child administer their own medication?	☐ YES	☐ NO	
* Dosage		* Frequency	
* Time/s to be administered			
* ☐ Before food ☐ With food ☐ After food ☐ Other – details:			
* The manner in which it is to be administered (e.g. oral, inhaler with spacer, injection, etc.)			
* Parent/guardians name		* Phone No	
* Parent/guardians signature		* Date	

LEAVE BLANK – TO BE COMPLETED BY OUR PATCH

Name of staff member receiving medication		Leaders name	
Staff member's signature		Leader's signature	

Child's Name: _____ Child DOB: ____/____/____

Name of Medication: _____ Program Name: _____

WHEN ADMINISTERING MEDICATION STAFF MUST CHECK DETAILS COMPLETED BY PARENT/GUARDIAN ON THE MEDICATION AUTHORITY FORM

To be completed by the educator when administered													
Name of medication	Last administered		Next Administration		Medication administered		Dosage Administration	Method of administration	Name of educator administering	Signature of educator administering	Name of witness	Signature of witness	XAP Record Complete
	Time	Date	Time	Date	Time	Date							

