



64 Baddeley Crescent | Spence ACT 2615 02 6258 8891 | admin@baringa.org.au www.baringa.org.au

ADMINISTRATION OF MEDICATION AUTHORISATION

AUTHORISATION OF CONSENT

By signing this Authorisation form, I declare that this has been completed in conjunction with the child's Medical Management Plan. I give permission for the Educators to administer the prescribed medication in accordance with the child's Medical Management Plan *or* if it is an 'over the counter medication' in accordance with directions on the packaging and directions of the authorising parent. I acknowledge that if the medication is prescribed to someone with a different name, or if it has expired, the medication cannot be administered at the service. (For exception consult regulation 94 of the Education & Care Services National Regulations, 2017.)

CHILD'S DETAILS							
Child's Name:	D.O.B:						
Name of parent authorising:							
Administration of medication authorisation is valid from// to/ (maximum two months)							
Signature:		Date:					
MEDICATION DETAILS							
Is it an over the counter medication?	/ES	NO					
Is the medication prescribed for the child?	YES	NO					
Name of Medical Practitioner prescribing the medication:							
Name of medication:							
Prescribed dosage:							
Method of administration:							
Time and date last administered:							
Time and date, or circumstances when medication should next be administered:							
Medication expiry date:							
SERVICE ACKNOWLEDGEMENT							
Educator:	Centre Director:						
Signature:	Signature:						
Date:	Date:						

NAME: D.O.B:





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Medication Administered		Dosage of Medication	Method of Dosage	Full name of person administering medication*	Signature	Full name of person witnessing medication	Signature
Time	Date			medication			

^{*}The educator administering the medication must hold a current First Aid Certificate. This form must be held on the child's file.