



## 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?	YES	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:

