TROPICS
EARLY LEARNING

ADMINISTRATION OF MEDICATION FORM

PERSONAL DETAILS			
Child's Name		Medical Practitioner	

MEDICATION					
Name of Medication		Is it to be administered short term or long term?	Short term ☐ Long term ☐	Date Prescribed	Expiry Date
Reason for Medication		Date and time of last dose given	Date: Time:		

INSTRUCTIONS: I request that the above medication be given in accordance with the following instructions:					
Date to be given (short term)		Time/s to be given (short term)		Can child self-administer	Yes ☐ No ☐
Route (eg; oral, inhaler)		Dose		Before or after food	

AUTHORISATION: Please note, this is to be signed by a parent/guardian, or authorised nominee					
Authorising person's full name		Signature		Date	

Date	Staff receiving medication	Time of last dose at home	Time Given	Dose Given	Manner it was administered	Name of staff administering medication	Signature of staff administering medication	Name of staff cross checking administration of medication	Signature of staff cross checking administration of medication

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