**MEDICATION ADMINISTRATION FORM**

**This form is to be used for all prescription medication and any over the counter medications given orally.**

Child’s full name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition which requires medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Storage requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of administration (and location for creams) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (or authorised person) Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full name of Educator receiving initial form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign: \_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*This form is valid for 5 consecutive days only\*\*\*\*\*\*\*\*\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Completed by parent/guardian upon arrival at service** | **Date** |  |  |  |  |  |
| **Time last dose administered** |  |  |  |  |  |
| **Name of medication** |  |  |  |  |  |
| **Dosage required** |  |  |  |  |  |
| **Time or circumstance when administered** |  |  |  |  |  |
| **Method (and location for cream)** |  |  |  |  |  |
| **Signature parent/guardian** |  |  |  |  |  |
| **Name of educator receiving medication** |  |  |  |  |  |
| **To be completed by educator receiving medication upon arrival** | **Original container with original label?** |  |  |  |  |  |
| **Does dose match label?** |  |  |  |  |  |
| **Medication expiry date:** |  |  |  |  |  |
| **Medication in date?** |  |  |  |  |  |
| **Where was this stored?** |  |  |  |  |  |
| **Name of educator communicated to:** |  |  |  |  |  |
| **To be completed upon administration of medication** | **Date administered** |  |  |  |  |  |
| **Time administered** |  |  |  |  |  |
| **Dosage administered** |  |  |  |  |  |
| **Method administered** |  |  |  |  |  |
| **Full name of educator administrating** |  |  |  |  |  |
| **Signature of educator** |  |  |  |  |  |
| **Full name of witness** |  |  |  |  |  |
| **Signature of witness** |  |  |  |  |  |
| **Upon Collection** | **Family signed dosage administered**  |  |  |  |  |  |
| **Medication collected** |  |  |  |  |  |