SHERWOOD STATE SCHOOL OSHC MEDICATION AUTHORITY FORM

MEDICATION AUTHORITY – to be completed by the Parent/Guardian

Child's Name: ..... **Date of Birth:** .....

Name of Medication: ..... **Expiry Date:** .....

Reason for Medication: .....

Please indicate how long this medication needs to be administered:

☐ Today only – Today's Date: .....

☐ For 2 or more consecutive attendance days (e.g. antibiotics)

Start Date: ..... Finish Date: .....

DETAILS OF ADMINISTRATION

Educators will only be able to administer medication if it is received in the original packaging, with a chemist label attached stating the child's name and/or doseage.

Doseage: ..... Time/s to be Administered: .....

Please circle: Before food / With food / After food .....

Time Medication was Last Administered: ..... Method of Administration: .....

Prescribing Doctor's Name: ..... **Phone No:** .....

Letter from Doctor/Medical Management Plan provided: Yes / No

Parent/Guardian's Name: ..... **Phone No:** .....

Parent/Guardian's Signature: ..... Date: .....

Educator's Name who received medication: ..... **Signature: .....**

Responsible Person in Charge's Name: ..... Date: ..... Time: .....