Medication Authorisation Form

This form is for the purpose of authorising usage of medication at our service. This includes self-administration of asthma medication for year 3-6.

TO BE COMPLETED BY PARENT

Child's full name:		**Date:**
Medication name:		
Name of issuing Doctor:		
Dosage required (as per label):		
Method of administration:		
Time/s to be administered:		
Expiry date of medication:		
Any additional circumstances for administration (after food, before food, etc.)		

**I hereby agree that the above information is correct and authorise centre staff to administer the medication as detailed above.

**I acknowledge that it is my responsibility to inform the staff IN WRITING should any of the above details change.

**The medication must be in its original packaging, have a medication label (prescription or pharmacy completed by a registered medical practitioner), clearly labelled with child name, dosage and other medication information.

**Staff will only administer recommended dosages per the medication label.

**Ill and sick children are required to be cared for at home.

**Staff cannot be held responsible for any reaction caused by the administration of this medication.

Parent Signature: _____**Date:** _____

For children with asthma in grade 3-6, parents may authorise self-administration of their ventolin/puffer after discussion with the nominated supervisor. Ventolin/puffer must stay in child's pocket at all times during the booking. If approved, please sign below.

Parent Signature: _____**Date:** _____

Nominated Supervisor Signature:_____ **Date:**_____