Medication Authority and Administration Form

(A separate form must be completed for each type of medication)

Child's Name: _____ Date: _____

No medication will be dispensed by a Mayfield OSHC educator to an enrolled child without this prior consent except in a medical or dental emergency, in which case Mayfield OSHC educators may act on the oral instructions of the child's GP, dentist, emergency services personnel (e.g. paramedics), or health care source listed on the child's emergency list.

Prescription medication: Must be in original packaging with a pharmacist's label which clearly states the child's name, dosage, frequency of administration, date of dispensing and is within the expiry period.

Non-prescription (over-the-counter medication): Must be in original packing bearing the original label and instructions and before the expiry or use by date.

Medication: _____

Condition prescribed for:_____

Possible side effects: _____

Instructions for storage and usage: _____

Time and date this medication was last administered by you: _____

Dosage required to be administered:_____

Method of administration: (circle applicable method) oral, eye, ear, inhaled, applied, other _____

Time: _____ Frequency: _____Start Date: _____ End Date: _____

Child's health care source has prescribed or recommended the medication named above and I request that the dosage(s) falling within Mayfield OSHC program hours be administered by Mayfield OSHC educators.

Signature of Parent or Guardian: _____ Date: _____
(necessary for both prescription and non-prescription medication)

Self-Administration (if applicable) I authorise for my child to self-administer the above medication and I understand the risks involved.

Signature of Parent or Guardian: _____ Date: _____

Mayfield OSHC Educators: Fill in date, time, dosage and signatures whenever dispensing medication.

Date	Time	Dosage amount & method of administration	Administered/ observed (if self-administered) by: Educator Full Name and Signature	Checked and witnessed by: Educator Full Name and Signature	Signature of Parent Notified

Date	Time	Dosage amount & method of administration	Administered/ observed (if self-administered) by: Educator Full Name and Signature	Checked and witnessed by: Educator Full Name and Signature	Signature of Parent Notified

When this medication was last administered:			
Date	**Time**	**Dosage amount & how administered**	**Parent/ Guardian Signature**