

LADY GOWRIE COMMUNITY KINDERGARTENS

MEDICATION PERMISSION FORM

In the interest of children's safety and well being, the Service staff will only administer medication if it is in its original container with the dispensing label attached listing the child as prescribed person, strength of drug and the frequency it is to be given.

Child's Full Name: _____

Medical Practitioner/Chemist etc: _____

Medication:

Name of Medication: _____

Date Prescribed: _____ Expiry Date of Medication: _____

Reason for Medication: _____

Storage Requirements: _____

Time and date of Last dose given:

Date	Time	Dosage Amount

I request that the above medications be given in accordance with the instruction below:

Date	Required time of Administration	Dosage amount required to be administered

General Instructions: eg. route (oral, inhaler), dose (eg thin layer, no. of drops/mls/tablets), before or after food. _____

Parents Full Name _____ Date: ___/___/___

Signature _____

Staff to complete on administration of medication:

Date	Dosage Given	Time Medication Given	Name of staff member administering medication (Min 2yr Qual)	Signature of staff administering medication	Signature of staff cross-checking medication	Comments