

SAMARITANS FIVE STAR FAMILY DAY CARE & IN HOME CHILD CARE



AUTHORISATION TO ADMINISTER MEDICATION

Child's name: _____ Date: _____

I give permission for _____ to administer the following medication _____

Please Note: All medication supplied must be in it's original bottle with pharmacist/homeopathic/naturopathic label

Dosage amount: _____ Time/s to be administered: _____

Special instructions and/or possible side effects: _____

Date of commencement: _____ Course Duration (no. of days): _____

Doctor's Name : _____ Phone No: _____

Child's Ailment: _____

Parent/Guardian Signature: _____ Date: _____

Record of Administration of Medication

Date: _____

Dosage: _____

Time Given: _____

Signature: _____

Educators: Please return Authorisation Form to Coordination Unit with Attendance Records when medication is completed. In the case of long term treatment, i.e. asthma etc, Authorisation Form is to be completed and returned with next attendance record and a copy taken. This copy will then need to be re-signed by the parent each fortnight.