Aranda Afters Association Incorporated

Medication Authorisation Form

Please complete the entire form in order to ensure your child's medicine is properly dispensed. All medicine must be in its original container, and labelled with the child's full name.

NB: Please complete one form per child and per medication prescribed for the child.

To be completed by the child's parent						
Child's Name						
Date of Birth						
Medicine Name						
Date Prescribed		Expiry Date				
Dosage Required						
Last Dose Given [If unsure or unknown write N/A]	Date		Time			
Time dose is required [If unsure or unknown write N/A]	Date		Time			
Administration Method [Please circle one method]	Ear	Eye	Oral	Applied	Inhaled	EpiPen
Special Instructions						
Parent Name						
Parent Signature			Date			

To be completed by the educator when medication is administered							
Medication Administered		Dosage Administered	Method of Administration	Name of Administering Educator	Signature of Administering Educator	Name of Witness	Signature of Witness
Date	Time						