Medication Authority, Short-term Illness

This Medication Authority is to be completed for medication administered on a temporary basis. A new form should be completed each week that the medication is required

Date / Week commencing: _____

Child's Name: _____ Date of Birth: _____

Name of medication: _____ Expiry date: _____

Storage requirements for medication if any (e.g. in refrigerator)

Doctor's instructions relating to administration: _

_____

Dosage _____ How Dosage is to be administered? (By mouth, syringe, topical cream, puffer etc.)

_____ _____

Time span for medication: From (date) _____ To (date) _____

Time(s) for medication to be administered: _____ am/pm _____ am/pm _____ am/pm

Name of Prescribing Doctor: _____ Telephone: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____

(STAFF USE ONLY)

Date			
Dosage administered **Time medication administered**	_____ am _____ pm	_____ am _____ pm	_____ am _____ pm
Staff member administering **Staff member administering**	_____ Name _____ _____ Signature Date	_____ Name _____ _____ Signature Date	_____ Name _____ _____ Signature Date
Staff member witness **Staff member witness**	_____ Name _____ _____ Signature Date	_____ Name _____ _____ Signature Date	_____ Name _____ _____ Signature Date