AUTHORITY TO ADMINISTER OR SELF ADMINISTER MEDICATION/S

Date: _____/_____/_____

I, _____ hereby give permission for
(parent/guardian name)

_____ to administer/or supervise self administration
to (name of educator)

my child _____DOB :_____ the following medication:
(child's name)

Name of Medication	Prescriber's name or OTC medication	Expiry Date	Dose	Times to be given		

Medication last given: Date: _____/_____/_____Time: _____ am/pm Dosage: _____

Reason for medication: _____

Signed: _____
(parent/guardian signature)

Over the counter medicine – Parent endorsement:
My child has not had a previous allergic reaction to the over the counter medicine described above, which the child has had on at least 3 previous occasions. My child's name is clearly printed on the medication.

Signed: _____
(parent/guardian signature)

Repeat authority:
If the above medication is required to be repeated within one week (Mon-Fri) parent/guardian to write repeat dates and initial each day the medication is to be administered. NB All over the counter medicines will only be administered for one day within the week, unless accompanied by your Doctor's instructions. (See Medical Policy).

_____/_____/_____ _____ _____/_____/_____ ____ _____/_____/_____ _____ _____/_____/____ ____
(date) (initial) (date) (initial) (date) (initial) (date) (initial)

Long Term Conditions:
On-going parent authority is provided on the Child's Special Health Needs Support Plan for children with long term conditions such as asthma or diabetes.

The service accepts no liability for any allergic reaction to medication that has been authorised by the parent/guardian on this form.

YMCA Family Resource Centre
PO Box 1201, Busselton WA 6280
Telephone (08) 9752 4033
Email info.frc@ymcawa.org.au

SELF ADMINISTRATION OF MEDICATION CHECKLIST

Name of Child:
_____

Criteria to be considered:

Criteria	Details
Age of child	
Period of time over which the child has self administered	
Child's competence to self administer	
Level of support required for the child to self administer	
Route by which the medication is taken	
Medication to be administered	
Child's Doctor's recommendations on the Special Health Needs Support Plan	
Parent/guardian and child's desires	

It is agreed that the child WILL / WILL NOT self administer their medication under educator supervision whilst at the service.

Parent / Guardian: _____ Date: ____/_____/____
Signature

Educator: _____ Date: ____/_____/____
Signature

The service accepts no liability for any unexpected reaction as a result of the child's self administration of medication authorised by the parent/guardian on this form.