



Samuel Gilbert Out Of Hours School Care Centre

Short Term Medication Form

Child's Name.....

Reason For Medication.....

Special instructions/possible side effects.....

Start date:..... End Date.....

All medications must be in the original pharmaceutical containers/packaging & within its use by date so the centre can be certain of the medication and dosages prescribed by the doctor

<u>Date</u>	<u>Name of child</u>	<u>Date and Time of last dosage</u>	<u>Name of medication</u>	<u>Expiry date</u>	<u>Dosage</u>	<u>Method</u>	<u>Time to be given</u>	<u>Self administered (Yes/No)</u>

TO BE COMPLETED BY PARENT/CAREGIVER

I request that my child..... be administered the above mentioned medication as per instructions provided. A copy of the dosage as prescribed by the medical practitioner is attached.

Signed..... Parent/Caregiver

Print Name.....Date.....

Short term medication request approved? Yes/No

Signed.....Nominated supervisor.....

Print Name.....Dated.....

Staff to complete

Date	Name of child	Name of medication	Expiry date	Dosage Given	Method	Time Given	Name of the staff who administered the medication (Name and signature)	Staff witness name and signature