Medication Administration Form

Child's Details

Child's Name:____ Age: ______________________
Known Allergies:____

Medication Details

Prescription Medication
Medicine Name: ____
Prescribed by: Doctor [ ] Pharmacist [ ] Qualified Nurse [ ]
Date medicine was dispensed: ____
Name as it appears on medicine: ____
Dosage: _____________________________________ Expiry date: _________________________
Refrigeration Required? Yes [ ] No [ ]

Over-the-counter Medication

Medicine name: _______________________________________ Expiry date: _____________________________
Doses already given today: ____

Medication Administration

Dosage 1: _________________________________ Time Administered: ___________________
Name of person administering medication:____________________________________
Signature: __________________________________
Comments ____
Dosage 2: _________________________________ Time Administered: ___________________
Name of person administering medication:____________________________________
Signature: __________________________________
Comments ____
Dosage 3: _________________________________ Time Administered: ___________________
Name of person administering medication:____________________________________
Signature: __________________________________
Comments ____

Please record medication administration below if medication is a week's course.

	Dose	Time	Initial	Dose	Time	Initial	Dose	Time	Initial
Mon									
Tue									
Wed									
Thurs									
Fri									

Parental Consent

I give permission for the above medication to be administered to my child. I have provided all information required in relation to the administration of the medication provided. I have read the mediation policy and agree to its content.

Parent's Name (Please Print): ______________________________ Signature: _________________

Acknowledgement
I acknowledge the medication administered to my child as above.
Parent's Name (Please Print): __________________________________ Signature:______________________