



## Medication Form/Administration of Medication Record

Medication must be in its original container with the pharmacy label and instructions intact

**Medication not in its original container will not be given (as per regulation 95)**

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage to be given: \_\_\_\_\_

Is this Medication (please select)–

- A one off script e.g Antibiotics, Cream etc.
- Ongoing e.g Ritalin, Insulin, Epilepsy Medication etc.
- As needed e.g Ventolin, Epi-Pen etc.

Is the medication prescribed by a Doctor: yes  no

Reason for giving medication: \_\_\_\_\_

The circumstances the medication should be given (with food etc.): \_\_\_\_\_

Manner in which medication is to be administered (orally, spacer & puffer etc.): \_\_\_\_\_

Time & date medication **was last** given \_\_\_\_\_ **(if applicable)**

Are there any side effects of the medication: \_\_\_\_\_

Time medication **is to** be given: \_\_\_\_\_ Time medication **is to** be given: \_\_\_\_\_

Comments or special Instructions:

\_\_\_\_\_

\_\_\_\_\_

I give permission for my child's medication to be administered in the following way;

- My child can self-medicate, and only needs the assistance of an educator to check dose.
- My child can self-medicate and will inform an Educator as soon as possible after administering their Medication, which has been prescribed for a chronic condition.
- My child cannot self-medicate; I would like 2 educators to check dosage and give medication to my child.

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coordinator Name: \_\_\_\_\_ Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_



