

Medication Authorisation Form 2022

Name of child D.O.B..... Today's date.....

Name of Medication

Reason for medication

Dose..... Time / Frequency

Route: Oral Topical (on skin) Inhaled Injection Other

Date start..... Date to stop..... Expiration

Additional Instructions / Comments

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Known side effects.....

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FOR PRESCRIPTION MEDICATION
Prescribing Health Care Provider.....
Phone number
Staff member signature
Staff member signature

I authorise (Setting name) staff member to administer the medication named above to my child in the manner stated. I release any liability in relation to the administration of the medication. I also acknowledge that I, the parent/ gaurdian, have given the first dose of this medication without any allergic or unexpected reations.

parent / guardian printed name Date signed.....

parent / guardian signature

RETURN OF MEDICATION
Return Date..... Parent signature.....
Staff signature.....