Medication Administration Request Form

Parental Authorisation (To be completed by the parent)

Child's Name: _____

Medication: _____
(Name that appears on label)

Reason for medication: _____

1. Dosage: _____
2. Time/Frequency: _____
2. Method: _____
4. How many days to be given? Mon Tue Wed Thurs Fri.
5. Ongoing: YES NO

Possible side-effects:

_____

_____

Details from Medical Practitioner regarding circumstances of use:

_____

_____

Parental/Guardian Signature: _____ **Date:** _____

Staff Action:

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			

Administration Details:

Day and Date	Time	Dosage	Signature	Checked By
Monday	AM: PM:			
Tuesday	Am: PM:			
Wednesday	AM: PM:			
Thursday	AM: PM:			
Friday	AM: PM:			