## Medication Authority Form



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l,	_ (full name), being the parent/guardian of (child's full name) ask the staff of					
Northwest Community Childcare to	administer the following medication as					
prescribed by my child's doctor.						
Doctor:	Phone Number:					
Medication (name):	Expiry Date: / /					
Reason for Medication:						
	Time to be Administered: AM/PM					
Time and Date of Last Dosage:						
Any Circumstances of Administration: _						
Method of Administration:						
My Child can Self-Administer their Medication whilst Supervised:						
Medication to be Administered from: / / to / /						

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Staff Use Only:

Date	Time	Dosage	Manner of Administration	Full Name and Signature of Administrator	Full Name and Signature of Witness



## Staff Use Only Continued:

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Date	Time	Dosage	Manner of Administration	Full Name and Signature of Administrator	Full Name and Signature of Witness