Queensland Lutheran
Early Childhood and School-Aged Care Services

WHS. 009 Medication Authorisation

V01.20

Service Name	St Paul's Lutheran Outside School Hours Care		
Child's Full Name		Date of Birth	
Name of Medication to be administered		Condition for which the medication is required	

Administration Instructions. Please provide details for ALL criteria below OR tick N/A

Does the medication need to be taken before/after or with food?	☐ N/A
Instructions if dosage missed (due to sleep patterns etc) e.g do/not administer late?	☐ N/A
Possible side effects?	☐ N/A

Dosage and method of administration, for example by mouth for liquids via syringe, applicator/hand for topical creams etc. Will the child self administer?

Storage instructions, does the medication need to be refrigerated?

What time[s] must the medication be administered? If required when symptoms occur please write 'as per HMF' (Health Management Form)

Parent/Guardian to complete

I hereby authorise an Educator/staff member to administer the medication/cream/lotion listed above ***or*** supervise them self administering, according to the dosage stated at the required time. I am aware that this form must be checked upon collection of my child to verify that medication has been administered accordingly. Any medication/cream/lotion WILL BE accompanied by a Doctor's letter or be labeled appropriately by a Pharmacist with current/relevant information; Child's name, date and dosage to be administered. **I understand that the Service will not administer medication with an expired used by date and have checked to ensure I have supplied medication that is in date.**

If your child is approved to self medicate this form must be accompanied by a ***WHS.048 Self Administration Acknowledgement*** form.

If the medication authorised on this form is ongoing I will complete Section A of the form, upon arrival each time my child attends the Services. *(additional space is provided over page)*

Parent/Guardian Name **Parent/Guardian Signature** **Date**

Section A. to be completed by Parent/Guardian | **Section B. To be completed by Staff administering the medication** | ***REMEMBER TO CHECK THE EXPIRY DATE***

Last administered Date	Time	Dose Administered	Parent/Guardian Name	Parent/Guardian Signature	Medication Administered Date	Time	Dose Administered	Method of Administration	Administered by Name	Signature	Witnessed by Name	Signature

Section A. to be completed by Parent/Guardian					Section B. To be completed by Staff administering the medication | *REMEMBER TO CHECK THE EXPIRY DATE*							
Last administered Date	Time	Dose Administered	Parent/Guardian Name	Parent/Guardian Signature	Medication Administered Date	Time	Dose Administered	Method of Administration	Administered by Name	Signature	Witnessed by Name	Signature

Copyright QLECS 2020. Permission is granted to copy this document and customise any open fields. Change to the content, format or layout constitutes a Copyright infringement.