FULLARTON PARK COMMUNITY CENTRE

MEDICATION AUTHORISATION FORM

CHILD'S DETAILS

First Name: .... **Last Name:** ....

All medication needs to be:

- In the original container
- Clearly marked with child's name
- The dosage as per prescribed medication

Over the counter medication must be accompanied by authorisation from a Medical Practitioner with the above mentioned criteria outlined including a date range for which the medication is relevant.

PARENT/GUARDIAN TO COMPLETE THIS SECTION

*** **Only medications prescribed in the child's name can be administered** ***

Do you consent to your child self-administering their medication (please circle)? Yes / No

Name of medication: ....

Type of medication: ....

Dosage required: ....

Method of administration: ....

....

Time to be administered or circumstances to be administered: ....

....

....

I .... *(name of parent/guardian)* give permission to staff of Fullarton Park Community Centre School Holiday Program to administer the above medication.

Signed: .... **Date:** ....

(Parent / Guardian)

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