ACT Public Preschool Daily Medication Administration Consent and Record Form

For all prescription, complementary and over-the-counter medications (Reg.92)

Child and Parent/Guardian Details				
Child's First and Last Name:		**Preschool Class name:**	
Date of Birth (DOB):		**Child's Known Allergies:**	
Parent/Guardian First and Last Name:		**Contact phone number for today:**	

Parent/Guardian to fill in details in this section

Medication Details					Last Dosage Given			Administration for Today		Name of staff member who discussed and checked parent instructions	I give permission for the use of this medication for my child as detailed. **Parent/guardian's signature:**
No.	**Date DD/MM/YY**	**Name of Medication** E.g. Amoxicillin	**Expiry Date MM/YY**	**Reason for Use** E.g. Respiratory Tract Infection	**Date**	**Time**	**Dose and how it was administered** E.g. orally with food	**Time of next dose at pre school**	**Dose and administration instructions** E.g. orally 1 hour before lunch with water		
1.											
2.											
3.											
4.											
Additional Parent/guardian instructions:											

1st Educator to record details. 2nd Educator to confirm all details and witness administration. Parent/guardian to view administration record and sign at the end of the session. Store in child's student file.

□Medication's original label/container checked				□Child's identity confirmed with 2nd Educator prior to administration					Child's identity and medication checked and witnessed by 2nd Educator		Parent Confirmation
No.	**Name of Medication**	**Expiry Date**	**Dosage request**	**Date Given**	**Time Given**	**Dose and administration manner**	**1st Educator's Name**	**Signature**	**2nd Educator's Name**	**Signature**	**Signature**
1											
2											
3											
4											

This record must be kept in the 'student record file' until the end of 3 years after the record was made

	1st Educator to record details. 2nd Educator to confirm all details and witness administration. Parent/guardian to view administration record and sign at the end of the session. Store in child's student file.										
	Medication's original label/container checked			Child's identity confirmed with 2nd Educator prior to administration					Child's identity and medication checked and witnessed by 2nd Educator		Parent Confirmation
No.	Name of Medication	Expiry Date	Dosage request	Date Given	Time Given	Dose and administration manner	1st Educator's Name	Signature	2nd Educator's Name	Signature	Signature
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