

BUNYA CHILD CARE CENTRE

Children's Health and Safety

Short Term Medication Form

Child's Name _____ **D.O.B** _____

Note: Person named must be authorised on child's enrolment record as an authorised person, to consent to administration of medication

Person requesting staff to administer medication

Name: _____ Signature: _____

Date(s): _____

Reason for the medication: _____

Name of the medication: _____

Dosage of the medication to be administered: _____

Time and circumstances under which the medication should be next administered (eg. before or after food or/as listed on prescription).

Time and date the medication was last administered

Date	Time given	Dosage given	Signature of staff administering medication	Signature of staff cross checking medication

Only medicine in its original container with the dispensing label attached will be administered.