OXANDA

Long Term Medication Form

Element 2.1.1 Each child's health needs are supported	DATE:	

AUTHORISATION OF CONSENT

By signing this Long Term Medication Record, I declare that this Record has been completed in conjunction with the child's Medical Management Plan. I give permission for the Educators to administer the prescribed medication in accordance with the child's medical management plan.

CHILD'S FULL NAME *(MUST APPEAR AS ON MEDICATION):*	
DATE OF BIRTH:	

PARENTS FULL NAME:	
PARENTS SIGNATURE:	
DATE:	

THIS LONG TERM MEDICATION FORM IF VALID FROM:	/ /	TO	/ /
PARENTS SIGNATURE:			
DATE:			

MEDICATION DETAILS

NAME OF MEDICATION *(AS SHOWN ON PACKAGING)*	
PRESCRIBED DOSAGE:	
METHOD OF DOSE: *(SPACER, TABLET ETC)*	
MEDICAL PRACTITIONER PRESCRIBING MEDICATION	
USE-BY DATE OF MEDICATION	

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DATE MEDICATION WAS LAST ADMINISTERED	TIME MEDICATION WAS LAST ADMINISTERED	DOSAGE ADMINISTERED	PERSON WHO LAST ADMINISTERED THE MEDICATION

TIME MEDICATION IS TO BE ADMINISTRATED AT THE SERVICE	TIME MEDICATION IS TO BE ADMINISTRATED AT THE SERVICE	TIME MEDICATION IS TO BE ADMINISTRATED AT THE SERVICE	TIME MEDICATION IS TO BE ADMINISTRATED AT THE SERVICE

ADMINISTRATION INSTRUCTIONS	

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DATE	EXACT DOSAGE	TIME ADMINISTERED	FULL NAME AND SIGNATURE OF PERSON ADMINISTERING MEDICATION	FULL NAME AND SIGNATURE OF PERSON WITNESSING MEDICATION ADMINISTRATION	PARENT ACKNOWLEDGMENT SIGNATURE