

Child's full name:	
Parent/guardian full name:	

- a prescribed medication by a registered medical practitioner; and in its original package with a pharmacist's label which clearly states the child's name, dosage, frequency of administration, date of dispensing and expiry date (reg 95).
- if unprescribed, the medication needs to be provided in original container with original chemist label and instructions attached.
- as a parent/guardian of the above-mentioned child, I request and authorise YMCA OSHC to administer the medication detailed in the administration information below or allow my child to self-administer if required.
- I warrant that the medication provided to YMCA OSHC with this authority is described in the administration information below and consistent with pharmacist's label
- I am aware that any information regarding changes to this medication including type, dosage, etc. must be completed on new authorisation to administer medication form.
- I am aware that it is my responsibility to maintain an adequate supply of this medication at YMCA OSHC.
- I am aware that I need to complete medication record

### Administration Information

Name of the medication as per pharmacist's label			
Is this medication self- administration?	<input type="checkbox"/> yes <input type="checkbox"/> no		
	If yes, educators need to supervise children when self-administering and complete the medication record		
Quantity provided to YMCA (tablets/ml)	<b>Date received</b>		<b>Amount received</b>
	<b>Repeat prescriptions</b>		
	Date received		Amount received
	Date received		Amount received
	Date received		Amount received
Period for which medication is to be administered	<b>Start date</b>		<b>Finish date</b>
	Reviewed each calendar year/ any change to the medication. New form to be provided after finish date.		
Doctor/ medical practitioner's name		Phone number	
Has the child taken this medication previously?	<input type="checkbox"/> yes <input type="checkbox"/> no		
	If yes, was there any adverse reaction? Please provide details:		
If no, the parent/guardian to provide the first dose to ensure the medication does not have adverse effect on the child			
Any other instructions			
Parent/guardian signature		Date	

<b>Responsible person checklist – to be completed before filing</b>			
<input type="checkbox"/> coordinator/ responsible person to cross check the pharmacy label for consistency of information with the form.			
<input type="checkbox"/> responsible person to inform relevant staff and have a record of conversation (staff communication).			
<input type="checkbox"/> depending on how you file, print at least 3 copies. A copy each for medication bag of the child, enrolment file and medication folder.			
<input type="checkbox"/> parent/ guardian to complete medication record.			
Admin/coordinator/ responsible person/ nominated supervisor name			
Signature		Date	

## Medication Record

Full name of the child \_\_\_\_\_

To be completed by the parent/Responsible Person								To be completed by the educator when administered							
Name of medication	Last administered (For after school care, includes instructions provided to the school)		To be administered next (or circumstances to be administered) For example, before food or after food		Dosage to be administered	Manner of administration (oral; nasal)	Signature of parent/Guardian	Medication administered		Dosage Administered	Manner of administration (oral; nasal)	Name of educator administering	Signature of educator administering	Name of witness	Signature of witness
	Time	Date	Time	Date				Time	Date						
(EXAMPLE) Zyrtec	8:00am	01/05/24	4:00pm	01/05/24	3ml	Oral	C.Della	4:00pm	01/05/24	3ml	Oral	John Smith	J.Smith	Jess Black	J.Black