AUTHORISATION TO ADMINISTER MEDICATION
07 - 534 AUTHORISATION

YMCA
We build strong PEOPLE
strong FAMILIES
strong COMMUNITIES

CHILD'S NAME:

PARENT/GUARDIAN NAME:

- ☐ As the parent/guardian of the above mentioned child I request and authorise YMCA BOWEN HILLS to administer the following medication.
- ☐ I warrant that the medication provided to YMCA Bowen Hills with this authority is that as described below.
- ☐ I am aware that any information regarding changes to this medication including type, dosage etc must be forwarded to YMCA Bowen Hills in writing.
- ☐ I am aware that it is my responsibility to maintain an adequate supply of this medication at YMCA Bowen Hills

PARENT SIGNATURE: DATE:

ADMINISTRATION INFORMATION

NAME OF MEDICATION:

PERIOD FOR WHICH MEDICATION IS TO BE ADMINISTERED: From: To:

TIME MEDICATION IS TO BE GIVEN:

MEDICATION DOSAGE:

DOCTORS NAME:

TELEPHONE: DOCTORS LETTER ATTACHED: Yes No

HAS THE CHILD TAKEN THIS MEDICATION PREVIOUSLY? Yes No

IF NO, STAFF ARE **UNABLE** TO GIVE ANY MEDICATION THAT HAS NOT BEEN PREVIOUSLY ADMINISTERED

IF YES, WAS THERE ANY ADVERSE REACTION? Yes No

IF YES, STAFF ARE **UNABLE** TO GIVE ANY MEDICATION THAT HAS NOT BEEN PREVIOUSLY ADMINISTERED.

SERVICE USE ONLY
The medication supplied with this authorization is:

- ☐ A prescribed medication; 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.

COORDINATOR SIGNATURE: DATE: