IGS Out of School Hours Care Program

Medication Administration Record Form

Name of Child: ____ Date of Birth: _____/______/_____ Notify the Responsible Person today ❑

Staff member receiving the form with the child's parent / carer: ______________________________

Is the child well enough to be at the program? Yes / No

Is the medication related to a child's Health Action Plan?

❑ Yes - Check the child's condition, medication, administration and dosage details match the plan

❑ No - Follow procedure with Medication Authority Form

To be completed by the parent / guardian								To be completed by the ELC staff member when administered					
Name of medication	Last administered		To be administered		Dosage	Method of administration	Signature of parent/ guardian	Medication administered		Dosage	Method of lministration	Staff member administering (1st aid qualified)	Staff member witnessing
	Date	Time	Date	Time				Date	Time				
							Name: Signed:					Name: Signed:	Name: Signed:
							Name: Signed:					Name: Signed:	Name: Signed:

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UNITY THROUGH DIVERSITY