

medication permission/administering form (17/12/19) (A separate form must be completed for each type of medication)

| Child's Nan | ne: | | Date: | · · | _ |
|--------------------------------------|---------------------------------------|---|--|---|----------------------------------|
| consent exce instructions o | ept in a me f the child': | edical or denta | al emergency in which c emergency services pers | ember to an enrolled child vase Mayfield OSHC staff moonnel (e.g. Ambulance) or | ay act on the ora |
| | om the child | d's health care | | armacy label is acceptable nust include the child's nam | |
| vitamins, etc | . this form n | nust be compl | | cetaminophen, cough med child's parent or guardian. the dosage required. | |
| Medication: | | | | | |
| Condition pr | escribed fo | r: | | | |
| Possible side | effects: | | | | |
| Instructions fo | or storage o | and usage: | | | |
| Time and da | te this med | ication was la | st administered by you: _ | | |
| Dosage requ | ired to be | administered:_ | | | |
| Method of A | dministratic | on: (circle appl | licable method) oral, ey | e, ear, inhaled, applied, otl | ner |
| Time: | | Frequency: | Start Date | e: End Date | : |
| | | | | ne medication named abo s be administered by Mayfi | |
| Signature of (necessary fo | Parent or G or both pres | Guardian: scription and r | non-prescription medica | Date: tion) | |
| Self-Administ understand t | | - | thorise for my child to se | lf-administer the above me | dication and I |
| Signature of Mayfield OSH | Parent or G IC Staff : Fill | Guardian: in date, time, | dosage and signatures v | Date: whenever dispensing medic | cation. |
| Date | Time | Dosage amount & how administer ed | Administered/Observ ed (if self- administered) by: Full Name and Signature | Checked and witnessed by: Full Name and Signature | Parents Notified Signature |
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