Rochedale Outside School Hours Care Association

ADDRESS	**Rochedale Road Rochedale Qld. 4123**		
TELEPHONE	**(07) 3841 1943**	**FAX**	**(07) 3340 8300**
MOBILE	**0419 490 297**	**EMAIL**	**roshca@rochedalesspandc.com.au**

Authorisation to Administer Medication

Authorisation for ROSHCA Staff to administer medication to my son/daughter as indicated below.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I, _____, request and authorise the following medication to be administered to my son/daughter.

1. Type of medication: _____
2. Name of medication: _____
3. Is this ongoing Medication: YES/NO
4. If this is ongoing medication do we have copy of the Doctors/Specialist certificate: YES/NO

	Monday	Tuesday	Wednesday	Thursday	Friday
Time					
Dosage					

5. Special instructions if medication is not taken at prescribed time (e.g. give as soon as possible, etc.) _____
6. Other instructions concerning this medication (e.g. must be taken with food etc.) _____

- I warrant that the medication provided to ROSHCA with this authority is that as described above.
- I understand that ROSHCA staff are unable to administer medication to my child unless the medication is supplied in its original pharmacy packaging. This packaging will include the above-named child's details including: the name of the medication, dosages and administration method.
- I realise that any information regarding changes to this medication including type, dosage, etc. must be forwarded to ROSHCA in writing.
- I understand that should I wish the administration of medication to be suspended for a particular day I am required to note this on the Medication Record form and sign and date the entry.
- I understand that should the administration of medication no longer be necessary I am required to notify the service in writing.
- I realise that it is my responsibility to maintain an adequate supply of this medication at the OSHC.
- I understand that should my child refuse medication, either before, during or after the process of staff attempting to administer the medicine, I will be contacted by ROSHCA and required to arrange for his/her immediate collection from the service.
- **This form remains valid until overturned in writing.**

PARENT/CARER SIGNATURE:

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CHILD'S NAME: _____ **DATE OF BIRTH:** _____

NAME OF MEDICATION : _____

To be completed by the educator when administered

Medication Administered		Dosage Administered (in mg)	Method of Administration	Name of educator	Signature of educator	Name of witness	Signature of witness
Time	**Date**						