LONG TERM MEDICATION RECORD

KATH DICKSON FAMILY DAY CARE
METROPOLITAN AND EAST COAST SERVICES | 1300 336 345

Educator first name: _____ Educator surname: _____

Parent first name: _____ Parent surname: _____ Parent Signature: _____

Child first name: _____ Child surname: _____ Child's Date of Birth: _____

By signing this long term Medication Record, you declare that this record has been completed in conjunction with the Child's Medical Management/Action Plan from the Child's Medical Practitioner. You give permission for the Educator to administer the prescribed medication in accordance with Child's Medical Management/Action Plan from the Child's Medical Practitioner.

MEDICATION DETAILS:

Name of Medication (As shown on Packaging): _____ Prescribed Dosage: _____

How is this be to Administered (Spacer, Tablet etc): _____ Medical Practitioner Prescribing Medication: _____

Use by Date of Medication: _____ This Long Term Medication Form is Valid From _____ /_____ /_____ to _____ /_____ /_____

(This is Annually Reviewed along with Child's Medical Management/Action Plan from the Child's Medical Practitioner)

EDUCATOR TO COMPLETE WHEN ADMINISTERED						EDUCATOR TO COMPLETE WHEN ADMINISTERED					
Name of Medication	Dosage Given	Dosage Given at		Signature of Educator Administering	Signature of Parent/Guardian	Name of Medication	Dosage Given	Dosage Given at		Signature of Educator Administering	Signature of Parent/Guardian
		Date	Time					Date	Time		

EDUCATOR TO COMPLETE WHEN ADMINISTERED						EDUCATOR TO COMPLETE WHEN ADMINISTERED					
Name of Medication	Dosage Given	Dosage Given at		Signature of Educator Administering	Signature of Parent/Guardian	Name of Medication	Dosage Given	Dosage Given at		Signature of Educator Administering	Signature of Parent/Guardian
		Date	Time					Date	Time		