Long Term Medication Form

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| --- | --- | --- |
| ***Element 2.1.1 Each child’s health needs are supported*** | DATE: |  |

AUTHORISATION OF CONSENTBy signing this Long Term Medication Record, I declare that this Record has been completed in conjunction with the child’s Medical Management Plan. I give permission for the Educators to administer the prescribed medication in accordance with the child's medical management plan.

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| --- | --- |
| CHILD'S FULL NAME *(MUST APPEAR AS ON MEDICATION):* |  |
| DATE OF BIRTH: |  |

|  |  |
| --- | --- |
| PARENTS FULL NAME: |  |
| PARENTS SIGNATURE: |  |
| DATE: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| THIS LONG TERM MEDICATION FORM IS VALID FROM: | / / | TO | / / |
| PARENTS SIGNATURE: |  |
| DATE: |  |

MEDICATION DETAILS

|  |  |
| --- | --- |
| NAME OF MEDICATION *(AS SHOWN ON PACKAGING)* |  |
| PRESCRIBED DOSAGE: |  |
| METHOD OF DOSE: *(SPACER, TABLET ETC)* |  |
| MEDICAL PRACTITIONER PRESCRIBING MEDICATION |  |
| USE-BY DATE OF MEDICATION  |  |

Long Term Medication Form

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| ADMINISTRATION INSTRUCTIONS |  |

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| --- | --- | --- | --- | --- | --- | --- |
| DATE | EXACT DOSAGE | TIME ADMINISTERED | FULL NAME OF PERSON ADMINISTERING MEDICATION | SIGNATURE | FULL NAME OF PERSON WITNESSING MEDICATION ADMINISTRATION | SIGNATURE |
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