kimberley kids
EARLY LEARNING CENTRE

Authority to Administer Medication Form

Parent to Complete

Parent/Guardian Name:	Child Name:
Prescriber of Medication: Doctor Pharmacist	
Reason for Medication:	
Name of Medication:	
Days to be Administered: Monday Tuesday Wednesday Thursday Friday	
Dosage to be Administered:	
Time of First Dose:	
Time of Subsequent Doses:	
Method/Instructions:	
Parent/Guardian Signature:	
Date:	

Qualified Staff to Complete

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	

Date:	Time:
Name of Medication:	
Dosage to be Administered:	
Checked By:	
Administered By:	