

# Community Living & Respite Services Inc. Club Teen Vacation & After School Care Program

**A00113878U ABN 44201747656**

**PH 03 5480 2388 FAX 03 5480 6860**

**PO BOX 424 ECHUCA 3564**

## MEDICATION PERMISSION FORM

In the interest of children's safety and well-being, Community Living and Respite Services Inc. only administer medication if it is in its original container or webster pack with the dispensing label attached listing the child as the prescribed person, strength of drug and the frequency it is to be given. This applies to all medications, regardless of whether they are non-prescribed (such as Panadol, cough medicines etc) or prescribed (antibiotics etc)

**CHILD'S FULL NAME..... MEDICAL PRACTITIONER/CHEMIST ETC.....**

**MEDICATION: NAME OF MEDICATION..... DATE PRESCRIBED.....**

**EXPIRY DATE OF MEDICATION..... REASON FOR MEDICATION.....**

**STORAGE REQUIREMENTS..... TIME AND DATE OF LAST DOSE GIVEN.....**

**ALLERGIES TO MEDICATION YES/NO IF YES NAME OF MEDICATION.....**

I request that the above medication be given in accordance with the instruction below:

Please complete table and list any detailed instructions in the box eg route (oral, inhaler), dose (eg thin layer, no of drops/mls/tablets), before or after food.

Instructions:

**PARENTS FULL NAME:.....**

**SIGNATURE..... DATE...../...../.....**

<b>DATE</b>	<b>TIME TO BE GIVEN</b>	<b>TIME GIVEN</b>	<b>SIGNATURE OF STAFF ADMINISTERING MEDICATION</b>	<b>SIGNATURE OF STAFF CROSS CHECKING MEDICATION</b>	<b>COMMENTS</b>
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