Medication Record

Please tick.

	Short-term	Valid for 24 hours
	Long-term	Valid for 3 months

Date: _____

Child's name: _____ Date of birth ____/____/____

Name of medication: _____

	Prescribed (doctors note must be provided)
	Non-prescribed (can administer once only)

Dosage: _____

Time/s to be administered: _____

	Administered	Administered by a qualified educator
	Self-administered	Self-administered by child whilst supervised by a qualified educator

I, _____, give permission for a qualified Little Graces ***educator to administer*** *the stated medication to my child.*

OR

I, _____, give permission for my ***child to self-administer*** *their stated medication.*

Parent/guardian signature: _____

Record of Administration of Medication

Date	Time	Dose	Staff/ Child Administering	Staff Sign	Witness Sign