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|  | **UFCC FORM** |  |
| **AUTHORIZATION OF DRUG/MEDICATION ADMINISTRATION** |

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| **Name of Child Care Centre:**  |
| **Child’s Full Name:**  |
| **Child’s Date of Birth** (dd/mm/yyyy)**:**  |
| **Date Authorization Form Completed** (dd/mm/yyyy)**:**  |
| **Name of Drug or Medication and Prescription # (if applicable):** |  | **Location of Medication:** |  |
| **Date of Purchase:** (dd/mm/yyyy) |  | **Authorization Start Date:** (dd/mm/yyyy) |  |
| **Expiry Date:** (dd/mm/yyyy) |  | **Authorization End Date:** (dd/mm/yyyy or ongoing) |  |

## Method of Medication Administration (initial below):

[ ]  Childcare centre staff are to administer the drug or medication to my child. \_\_\_\_

[ ]  My child will self-administer the drug or medication (optional, for children who attend school only). \_\_\_\_

## Medication Administration Schedule

[ ]  The drug or medication needs to be administered according to the following schedule:

| **Day(s) of the Week or “As Needed”** | **Time(s) of the Day or Symptoms** | **Amount/Dosage** | **Additional Information (where applicable)** |
| --- | --- | --- | --- |
|  |  |  |  |

**Parent/Guardian Authorization Statement:**

[ ]  I hereby authorize the person in charge of drugs or medications at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of childcare centre) to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form.

[ ]  I understand that expired drugs or medications will not be administered to my child at any time in accordance with the childcare centre’s medication administration policy.

[ ]  I understand that staff are not medically trained to administer drugs and medications.

|  |  |
| --- | --- |
| **Print name:** | **Relationship to Child:** |
| **Signature:** | **Date Signed:** (dd/mm/yyyy) |

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|  | **UFCC FORM** |  |
| **RECORD OF DRUG/MEDICATION ADMINISTRATION** |

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**Child’s Full Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Centre**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age Group:**  Infant  Toddler  Preschool  Kinder  School Age **Date Form Completed (D/M/Y)**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF MEDICATION:**

**MEDICATION ADMINISTRATION SCHEDULE** - to be administered according to the following schedule:

|  |  |  |  |
| --- | --- | --- | --- |
| **Day(s) of the Week OR** **As Needed** | **Time(s) of the Day OR** **Symptoms to observe** | **Amount/Dosage** | **Additional Information** (if applicable) |
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| **Date (DD/MM/YY)** | **Time****(HH:MM AM/PM)** | **Dosage Administered** | **Administered by** | **Full PRINTED Name of Staff/ Witness** | **Staff Initial** | **Notes/Observations****(Including symptoms of illness)** |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |
|  |  |  |  Staff  Child Parent/ Guardian |  |  |  |