ECE service/school and child/young person information

Name of ECE service or school: .....

Name of child or young person: .....

Child or young person's date of birth: ..... Group/class/form: .....

Health condition: .....

Medical information: .....

Medication name/type (as described on the container): .....

Date dispensed: ..... Expiry date: .....

Dosage and method: .....

Times to be given: .....

Special precautions: .....

Side effects: .....

Self-administration: Yes ☐ No ☐

Emergency procedures: .....

GP/health professional information

Name: .....

Daytime telephone: .....

Parent/caregiver information

Name: .....

Address: .....

Daytime telephone: .....

Work telephone: .....

Mobile: .....

Relationship to child: .....

Signatures

EITHER

I …….. (ECE service manager/principal) understand that a designated staff member must deliver the medication personally to …….. (name of child/young person).

It is agreed that …….. (name of child/young person) will receive …….. (quantity and name of medication) every day at …….. (time/frequency).

OR

…….. (name of child/young person) will be supervised while he or she takes medication by …….. (name/s of staff member).

This arrangement will continue until …….. (either end date of course of medication or until instructed by parents/caregivers).

Signature (ECE service/principal): ..... Date: .....

I …….. (print name of parent/caregiver) understand that I must notify the ECE service/school of any changes in writing. I agree for the ECE service or school to administer medication.

Signed: ..... Date: .....