Medication Authorisation Form

Child's Information:

- Child's Name: _____
- Date of Birth: _____ Age: _____ Gender: _____
- Parent/Guardian Name: _____
- Contact Number(s): _____
- Emergency Contact Name: _____
- Emergency Contact Number: _____

Physician's Information:

- Physician's Name: _____
- Physician's Phone Number: _____

Medication Information:

- Medication Name: _____
  - Dosage: _____
  - Route (oral, topical, etc.): _____
  - Time(s) to be administered: _____
  - Reason for medication: _____
  - Start Date: _____ End Date: _____
  - Special Instructions (storage, administration): _____

- (If more medications are required, please use additional forms.)

Authorisation: I, the undersigned, authorise Queensland Paediatric Allied Health staff to administer the above medication to my child as prescribed. I have provided all necessary information regarding this prescription and confirm that the medication is labeled with my child's name, the medication name, dosage, and prescribing doctor's name. I understand Queensland Paediatric Allied Health's policies regarding medication administration and agree to inform the program immediately of any changes to this prescription or the need for its administration.

I release the vacation care program and its staff from liability in the event of an adverse reaction to the medication as long as the medication was administered in accordance with the instructions provided on this form.

- Parent/Guardian Signature: _____
- Date: _____

For Program Use Only:

Medication Received By (Staff Name): _____

Date Received: _____

Time Received: _____

Medication Returned to Parent/Guardian: Yes [ ] No [ ] Staff Signature: _____

Date: _____