HUGS & KISSES
EDUCARE CENTRE CC

1992/030768/23

11 MIRWANI ROAD
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MEDICATION AUTHORISATION FORM
2020

Child's name and age: _____

Child's group:	Fishes	Teddies	Tiggers	Owls

1: Name of medication:		Was the medication prescribed by a doctor?	**Please Tick:**	**Dosage:**	
			YES	Quantity:	
			NO	Time:	
Indication for medication:		Or is it a medication available over the counter?	**Please Tick:**	**Length of time that your child must receive the medication for:**	
			YES	Start Date:	
			NO	End Date:	
Must the medication be stored in the refrigerator?			**Please Tick:**	YES	NO
Any side effects associated with the medication?					
Any precautions that should be taken whilst your child is on the medication?					
Signed:			Date:	____ / ____ / 2020	

2: Name of medication:		Was the medication prescribed by a doctor?	**Please Tick:**	**Dosage:**	
			YES	Quantity:	
			NO	Time:	
Indication for medication:		Or is it a medication available over the counter?	**Please Tick:**	**Length of time that your child must receive the medication for:**	
			YES	Start Date:	
			NO	End Date:	
Must the medication be stored in the refrigerator?			**Please Tick:**	YES	NO
Any side effects associated with the medication?					
Any precautions that should be taken whilst your child is on the medication?					
Signed:			Date:	____ / ____ / 2020	

3: Name of medication:		Was the medication prescribed by a doctor?	**Please Tick:**	**Dosage:**	
			YES	Quantity:	
			NO	Time:	
Indication for medication:		Or is it a medication available over the counter?	**Please Tick:**	**Length of time that your child must receive the medication for:**	
			YES	Start Date:	
			NO	End Date:	
Must the medication be stored in the refrigerator?			**Please Tick:**	YES	NO
Any side effects associated with the medication?					
Any precautions that should be taken whilst your child is on the medication?					
Signed:			Date:	____ / ____ / 2020	

4: Name of medication:		Was the medication prescribed by a doctor?	**Please Tick:**	**Dosage:**	
			YES	Quantity:	
			NO	Time:	
Indication for medication:		Or is it a medication available over the counter?	**Please Tick:**	**Length of time that your child must receive the medication for:**	
			YES	Start Date:	
			NO	End Date:	
Must the medication be stored in the refrigerator?			**Please Tick:**	YES	NO
Any side effects associated with the medication?					
Any precautions that should be taken whilst your child is on the medication?					
Signed:			Date:	____ / ____ / 2020	

5: Name of medication:		Was the medication prescribed by a doctor?	**Please Tick:**	**Dosage:**	
			YES	Quantity:	
			NO	Time:	
Indication for medication:		Or is it a medication available over the counter?	**Please Tick:**	**Length of time that your child must receive the medication for:**	
			YES	Start Date:	
			NO	End Date:	
Must the medication be stored in the refrigerator?			**Please Tick:**	YES	NO
Any side effects associated with the medication?					
Any precautions that should be taken whilst your child is on the medication?					
Signed:			Date:	____ / ____ / 2020	