P&C Association
KENMORE SOUTH STATE SCHOOL
Lunchbox OSHC Uniforms

Medication Authority

to be completed by the parent/guardian

Child's Name:	D.O.B:
Name of medication:	Expiry Date:

Reason for medication:
Medication storage instructions (eg to be refrigerated): * Please note, if medication is kept in the child's bag, their bag MUST be kept in the OSHC office to ensure it is kept away from other children and in reach if needed

Frequency of medication

☐	Today Only	Today's date:	
☐	2 or more consecutive attendance days (e.g. antibiotics)	Start Date:	Finish Date:
☐	Ongoing regular medication	Start Date:	

Details of Administration

Staff will only be able to administer medication if it is received in the original packaging, with a chemist label attached stating the child's name and dosage. All medication is administered under adult supervision.

Circumstances of administration:	☐ When needed	☐ With food	☐ Before food	☐ After food

Prescribing Doctors name:	Phone number:
Letter from doctor/medical management plan provided	☐ Yes ☐ No (required for ongoing medical conditions)

I give permission for my child to administer his/her own medication *If yes, the child must come to an educator to witness the administration of the medication	☐ Yes ☐ No
I give permission for my child to use KSSS OSHC prescribed medication if needed *please note, KSSS OSHC medication will only be used if the same as detailed above	☐ Yes ☐ No

Parent/Guardian Name:	Phone Number:
Signature:	Date:

Educator receiving Medication:	
Signature:	Date:
Coordinator Name:	Signature: