LITTLE FEATS OOSHC
AS REQURIED
MEDICATION AUTHORISATION

Medication must be in its original container with the pharmacy label and instructions intact Medication not in its original packaging will not be given/administered	
Name of Child:	
Name of Medication:	
Dosage to be given:	
Is the medication prescribed by a Doctor:	YES ☐ NO ☐
Time medication is to be given:	_____:_____ AM ☐ PM ☐
Time medication was last given:	_____:_____ AM ☐ PM ☐
Reason for giving medication:	
Manner in which medication is to be administered (oral, skin cream, eye drops, syringe, injection, other)	
Are there any side effects of the medication:	
Comments or Special Instructions:	
I give permission for my child's medication to be administered in the following way: ☐ My child can self-medicate and requires the assistance of only one (1) Little Feats staff member to check the dosage. ☐ My child cannot self-medicate. I would like the assistance of two (2) Little Feats staff members to check the dosage and provide medication to my child.	

Parent Name: _____ **Parent Signature:** _____ **Date:** ____ /____ /____

Date	Dosage	Time Given	Manner Given	Educator's Name & Signature	Witness or Child's Name & Signature

Date	Dosage	Time Given	Manner Given	Educator's Name & Signature	Witness or Child's Name & Signature