LITTLE FEATS OOSHC ONGOING 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 each day:	_____:_____ AM ☐ PM ☐
Time medication is 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