

Melton City Council - Medication Record

Child's Full Name Date of Birth

Parent/Guardian Full name Child's condition/allergies

Parents / Guardians Please Note - All medication, prescribed or non-prescribed, to be administered or self-administered, needs to be handed to staff, authorised by the parent or authorised person (Regulation 92). Confirm the child is capable and willing to self-administer medication if relevant. If medication is prescribed it must be in its original container and label with the name of the child and expiry date. The prescribed medication can only be administered in accordance with any instruction attached to the medication. Medical Management Plan is from a registered medical practitioner (Regulation 95). Verbal consent in an emergency is acceptable from a parent/guardian, or from a registered medical practitioner or medical emergency services if the child's parent/guardian cannot be contacted, this form completed by the educator and witness. In the case of an Anaphylaxis or Asthma emergency, Medication may be administered to a child without authorisation following the direction of the child's Medical Management/Action Plan. The child's parent/guardian and/or emergency services must be contacted as soon as possible after event (Regulations 93-94). A Communication & Risk Minimisation form must be completed for long term medications or those used for more than 48 hours.

Parent/guardian to fully complete below and authorise each day (or annually for ongoing medication e.g. inhaler / EpiPen / sunscreen)											
Name of medication and expiry date	Last administered (or N/A for long term)			To be administered (circumstances, 'week', 'year' if ongoing e.g. EpiPen / Inhaler)		Dosage and method to be administered (or preschool age or above self-administered or follow Action Plan e.g.	Communication & Risk Minimisation Plan (C&R) must be completed for long term medication	Signature of Parent/Guardian / Authorised person when medication is Handed to staff	Signature of Parent/Guardian /Authorised as medication is collected		
	Date	Time	Dose	Date/s	Time/s	Anaphylaxis or Asthma)	Yes, or N/A				

STAFF to complete (as	WITNESS to complete						
Check – original container & label, child name, dosage, method, expiry date	Check – Communication & Risk Minimisation Plan completed?	Medication administered (or preschool age or above self-administered?)		Name of Person administering medication (including self- administered)	Signature of Person administering medication (including if self- administered)	Name of witness I have checked the administration of medication as authorised	Signature of witness
Initials of Educator	Initials of Educator	Date Time					