Long Term Medication Form

Child's Name: _____ Date of Birth: ___ / ____ / ___

Name of Medication: _____ Medication Expiry Date: ___ / ___ / ___

Dosage: _____ Dosage Method: _____

Time for Administration: _____

I give permission for staff of Albany Hills Outside School Hours Care to administer the above medication and dose at the required time. This agreement is valid for 3 months from ___ / ___ / ___ to ___ / ___ / ___.

Parent Name: _____ Parent Signature: _____ Date: ___ / ___ / ___

Date	Dose Administered	Time	Staff Administering	Staff Signature	Witness	Witness Signature

Date	Dose Administered	Time	Staff Administering	Staff Signature	Witness	Witness Signature