3 Month Medication Record

By completing and signing this form, you are allowing permission for Albany Hills OSHC educators to administer the medication and dose outlined below.

Child's Name: .....

D.O.B: .....

Parent Name: .....

Signature: .....

Record start: .....

Medication: .....

Expiry Date: .....

Dosage Method: .....

Dosage: .....

Record Expiry: .....

Notes:

Date	Dose	Time	Administering Staff	Signature	Witness	Signature

Date:	Dose	Time	Administering Staff	Signature	Witness	Signature