# MONTESSORI STEPPING STONES

## AUTHORITY TO ADMINISTER MEDICATION FORM

| Date: | | | | |
|---|---|---|---|---|
| I (full name), | | | | |
| hereby give permission to trained educators/staff at Montessori Stepping Stones ™ | | | | |
| to administer / or supervise self administration to my child, | | | | |
| (full name): | | | | |
| the following medication (exact descriptions) | | | | |
| **Name of Medication** | **Prescriber's name or OTC medication** | **Expiry Date** | **Dosage** | **Times to be given** |
| | | | | |
| | | | | |
| | | | | |
| Medication last given: | **Date** | **Time:** | **Dosage:** | |
| Reason for medication : | | | | |
| (Parent/guardian signature): | | | | |
| **Over the counter medicine - Parent/Guardian endorsement**<br>**My child has not had a previous allergic reaction to the over the counter medicine described above, which the child had on at least 3 previous occasions. My child's name is dearly printed on the medication.** | | | | |
| (Parent/guardian signature): | | | | |

**Repeat authority:**
If the above medication is required to be repeated within one week (Mon. to Fri.) parent/guardian to write repeat dates and initial each day the medication is to be administered. **All over the counter medicines will only be administered for one day within the week, unless accompanied by your Doctor's instructions.** (See **MSS.P21 Medication & Medical Conditions Policy**)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| (Date) | (Initial) | (Date) | (Initial) | (Date) | (Initial) | (Date) | (Initial) |

**Long Term Conditions:**
On-going parent authority is provided on the child's Special Health Needs Support Plan for children with long term conditions such as asthma or diabetes.

Note: MSS accepts no liability for any allergic reaction to medication that has been authorised by the Parent/guardian on this form.

# MONTESSORI STEPPING STONES

## AUTHORITY TO ADMINISTER OR SELF ADMINISTER MEDICATIONFORM (CONTINUED)

**FOR EDUCATOR/STAFF USE ONLY**

**Note: OTC Medication ONLY to be administered ONCE within the week, unless accompanied by Doctor's instructions.**

| **Name of child:** | |
|---|---|

| **Medicine:** | **Expiry date:** | **Dose:** | **Date/Time:** | **Given/Supervised by:** (Name/Signature) | **Checked by:** (Name/Signature) |
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