ruby & ollies
POSSIBILITIES FOR KIDS OF ALL ABILITIES

LONG-TERM MEDICATION AND EMERGENCY MEDICATION PERMISSION FORM

- This form is for medications that are required to be administered over a period of time due to prolonged medical conditions.
- The form will remain current until the 30 June each year.
- For Emergency Medication an Action Plan completed by a medical practitioner should accompany this form.
- There must be a Medical Risk Minimisation and Communication Plan completed together between the family and the service.
- Depending on circumstances, educators will attempt to contact the parent/guardians or medical practitioner prior to use however in the case of a medical emergency such as a severe asthma attack or allergic reaction educators will administer as directed below.

DETAILS MUST MATCH THE MEDICAL ACTION PLAN PROVIDED BY THE MEDICAL PRACTIONER

Child's Full Name:	Name of medication to be administered:
Is there a current Action Plan provided by a Medical Practitioner? Y / N	Date of Plan:
Name of Medical Practitioner:	Medical Centre Contact Details:
Name of Medical Centre or Hospital:	Reason for medication:
Has the Medical Risk Minimisation and Communication Plan been completed? Y / N	Date:
Method of Administration:	Prescribed dosage as per Action Plan:
When Medication should be administered (Symptoms/ regular times):	

A PHARMACY/DOCTOR LABEL MUST BE AFFIXED TO THE MEDICATION

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PARENT/GUARDIAN: I give permission for an educator to administer the named medication as per **the instructions on the Action Plan provided by the medical practitioner or Pharmacy/ Doctor Label**. I understand that, in the event of an emergency, educators will attempt to contact parents/guardians or authorised nominee as per the child's enrolment form prior to administering however if unable to do so educators will act based on the above details. I authorise the centre to contact the Ambulance Service in the event that my child requires further medical attention and authorise the transportation and treatment as advised by Medical Staff. I accept all financial costs related to the transportation and treatment required. I understand that the health and safety of my child is the main priority at the service and as such information about my child's allergies or serious medication conditions may be on display, including their picture and name. While this information is primarily for the educators at the service it may be viewed by students, volunteers, visitors and other families. A condition of enrolment at this service is that this information is readily available to ensure your child's safety.

Parent/Guardian Full Name: _____ Signature: _____ Date: _____

Nominated Supervisor: _____ Signature: _____ Date: _____

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Child's Full Name:
Name of medication to be administered:

RECORD DOSAGE ON THE REVERSE OF THIS FORM

EDUCATOR TO COMPLETE WHEN DOSE IS PROVIDED											
Date	**Time**	**Expiry Date**	**Dose**	**Method**	**Reason for administration**	**Medical Attention Sought**	**Educator Full Name**	**Educator Signature**	**Witness Full Name**	**Witness Signature**	**Parent Signature**

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Child's Full Name:
Name of medication to be administered:

RECORD DOSAGE ON THE REVERSE OF THIS FORM

EDUCATOR TO COMPLETE WHEN DOSE IS PROVIDED											
Date	**Time**	**Expiry Date**	**Dose**	**Method**	**Reason for administration**	**Medical Attention Sought**	**Educator Full Name**	**Educator Signature**	**Witness Full Name**	**Witness Signature**	**Parent Signature**

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Child's Full Name:
Name of medication to be administered:

RECORD DOSAGE ON THE REVERSE OF THIS FORM

EDUCATOR TO COMPLETE WHEN DOSE IS PROVIDED											
Date	**Time**	**Expiry Date**	**Dose**	**Method**	**Reason for administration**	**Medical Attention Sought**	**Educator Full Name**	**Educator Signature**	**Witness Full Name**	**Witness Signature**	**Parent Signature**