

**Gum Nut Preschool & Child Care**

1 Como Street, Alphington. Vic. 3078 Ph: (03) 9499 4410 Fax: (03) 9440 9531 Email: office@gumnutpreschool.com.au

**Medication Record**

This form is for: (Please circle a or b)

- a. Prescribed medication (e.g. antibiotics, lotions).
- b. Un-prescribed medication (e.g. Paracetamol, cough mixture). Only 1 day per week.

Child's full name: \_\_\_\_\_ Child Date of Birth:.....  
Date: \_\_\_\_\_

***I give permission for the staff at Gum Nut Preschool & Child Care to administer the medicine described below:***

Parent / Guardian full name: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medicine (Name): \_\_\_\_\_ Expiry date: \_\_\_\_\_

**Time and date LAST dose was administered:**  
\_\_\_\_\_

Time and date, & the circumstances under which, the medication should next be administered ("when necessary") will not be accepted): Time/s; \_\_\_\_\_ Date; \_\_\_\_\_

Circumstances:& **Reason for medication**  
\_\_\_\_\_

**Dosage to be administered:** \_\_\_\_\_

**Method of administration:** \_\_\_\_\_

<b>Staff Section:</b>	
Dosage that was administered: _____	
Time and date medication given: Time: _____	Date: _____
Person who gave medication: Full name: _____	Sign: _____
Person who checked the dosage and medication given: Full name: _____	Sign: _____
Dosage that was administered: _____	
Time and date medication given: Time: _____	Date: _____
Person who gave medication: Full name: _____	Sign: _____
Person who checked the dosage and medication given: Full name: _____	Sign: _____