



ROWVILLE AND DISTRICT NEIGHBOURHOOD HOUSE INC.
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**VACATION CARE PROGRAM CONFIDENTIAL MEDICATION AUTHORISATION FORM
ONE FORM PER DAY ON ADMINISTERING MEDICATION**

Child Name: _____

Age: _____

PARENT / GUARDIAN TO COMPLETE

Medication Name: _____

Is the medication in the child's name? Yes No

If no, is the medication prescription only? Yes No

If Yes, medication cannot be administered.

If No, consult with staff, and check instructions as per box.

Is the medication within expiry period? Yes No

Dosage(s) Required: _____

Method is to be administered: _____

Time(s) to be administered: _____ : _____ am/pm _____ : _____ am/pm

Parent / Guardian Signature: _____ Date: / / 2011

STAFF TO COMPLETE

Is the medication in the child's name? Yes No

If no, is the medication prescription only? Yes No

If Yes, medication cannot be administered.

If No, check instructions as per box.

Is the medication within expiry period? Yes No

Dosage(s) Administered: _____ Time of Dosage: _____ : _____ am/pm
: _____ am/pm

Signature of administering staff member: _____ Date: / / 2011

Medication checked and witnessed by additional staff member: _____

Additional staff member name: _____

Parent / Guardian signature upon collection of child: _____