PROSPECT CENTRE COMMUNITY CHILD CARE

Medication Form
Ongoing / Longer Term - 3 mths

Child's Full Name_____ Date of Birth_____

Doctor's Name and Contact Details _____

Medication_____

Dosage/Application_____

Action Plan - Epipen/Asthma/Cortisone Cream/ etc from Doctor YES / NO

Date form Completed_____ Review Due_____

Signed and Dated Parent_____

Date Given	Dose	Signed Staff	Witnessed Staff	Time	Signed Parent

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Pharmacy Medication Permission Form
Short Term

Child's Full Name_____ Date of Birth_____

Pharmacy Medication Name _____
(eg Panadol, Dymadon, curash, bonjela)

Dosage/Application_____

Parent Request Date	Dose	Signed Parent	Signed Staff	Time	Witnessed Staff

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