# Kat's Care Services

## AUTHORISATION TO ADMINISTER MEDICATION

Name of Participant:_____

Medication Name:_____ Dosage:_____

Circumstances to be given (please circle): Before Meal, After Meal, or when required _____

_____

Directions to administer: _____

To Cover Period From_____ to _____

I give permission to _____ (Provider)

to administer the above medication to _____

Signed:_____ Date: _____

PLEASE NOTE: *If any of the details above change a new form must be filled out.*

| Date | Time last given | Time to be given | Special Instructions | Parent/ Guardian Signature | Dose | Time given | Provider signature |
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***2011 Education and Care Services Regulations (Clause 92)***

## Medication Administration 3 months

| Date | Time last given | Time to be given | Special Instructions | Parent/ Guardian Signature | Dose | Time given | Provider signature |
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