HAPPY LITTLE PEOPLE
OVER THE COUNTER MEDICATION CONSENT FORM

Child's Name: _____Date: _____

Medication_____

Reason for Medication: _____

Date of first dose of medication: _____

Date and dose of the medication last administered by the parent: _____

Date due to complete the course of medication: _____

Dosage: _____Frequency:_____

Please list any other medication that your child is currently using, and state if these has been prescribed or purchased over the counter (OTC)_____

_____

Does your child have any allergies? YES/NO Please state: _____

Please list any special instructions: _____

_____

I CONFIRM THAT

- This is not the first dose of this medication that my child has had.
- I authorised the staff at TASC to support my child to administer this medication
- I have been issued or accessed a copy of the administration of medication policy
- I understand that all medication will be stored appropriately and administration will be logged

Parent's Signature:_____ Date: _____

Designated Staff member: _____ Date: _____

THE MEDICATION WAS RETURNED TO PARENT/CARER ON _____

PARENT'S SIGNATURE _____ DATE _____

STAFF SIGNATURE: _____ DATE: _____