PERMISSION TO ADMINISTER MEDICINE/TREATMENT OVER AN EXTENDED PERIOD

Child's Name: _____ Date permission given by parent: _____

Name of medicine or description of treatment: _____

Training received on: _____ By: _____

Routine: _____

Emergency: _____

Required dose or treatment: _____ When to administer: _____

Start date: _____ Parent's signature: _____ Practitioner's signature: _____

Date/time medication or treatment administered	Practitioner to initial when administered	Parent to initial after confirmation of administration

Date/time medication or treatment administered	Practitioner to initial when administered	Parent to initial after confirmation of administration

It is the parent's responsibility to inform the setting when the treatment is no longer required

Date medication/treatment ceased: _____ Record of any adverse reaction to medication/treatment:_____

_____