Long Term Medication Authority

This Medication Authority is to be completed for medication administered over a prolonged period on a regular basis. This form must be updated every 6 months or if the medication is varied in any way, eg: altered dosage. All medication must have an accompanying doctor's letter. Please ensure Parent/Guardian signs after each dose.

Date: ___/___/___ Child's Name: _____ DOB: ___/___/___ Name of Medication:_____

Dosage to be administered: _____ Condition which requires medication:_____

Time span for medication: From (date) ___/___/___ to (date) ___/___/___ Times for medication to be administered: _____

Name of prescribing doctor: _____ Telephone: _____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date: ___/___/___

Team Member Name: _____ Team Member Signature: _____Date: ___/___/___

(Staff Member Use Only) – Complete record of administration of Long Term Medication in table below:

Date	Time	Dosage	Name of Medication	Team Member Name	Team Member Signature	Witness Name	Witness Signature	Comments	Parent/Guardian Signature

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Date	Time	Dosage	Name of Medication	Team Member Name	Team Member Signature	Witness Name	Witness Signature	Comments	Parent/Guardian Signature

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Date	Time	Dosage	Name of Medication	Staff Member Name	Staff Member Signature	Witness Name	Witness Signature	Comments	Parent/Guardian Signature