The Summit After School Care & Vacation Care Centre.

SHORT TERM PRESCRIPTION MEDICATION AUTHORISATION FORM

Date Authorisation Given: _____

Child's Name:

_____

Days Attending: MON TUE WED THU FRI

Medication Name: _____

Time Medication to be Administered: _____

Dosage: _____

Special Instructions:_____

_____

_____

Signature Parent/Caregiver: _____ Date: _____

Date Given	Time Given	Dose	Given By	Witnessed By

The Summit After School Care & Vacation Care Centre.

LONG TERM MEDICATION AUTHORISATION FORM

Medication Name	
Amount	
Frequency of application	
Dispensing Label or Letter	
Date	
Parent/Caregiver Signature	

Date Given	Time Given	Dose	Given By	Witnessed By

The Summit After School Care & Vacation Care Centre.

Date Given	Time Given	Dose	Given By	Witnessed By