

Medication Record

Childs name:	. Date of birth:				
I hereby give permission to qualified Centre state (Parent/ Guardian name)	aff at Butterfly Childcare to administer to my child the following medication.				
Over the counter medicine – Parent's endorsement (N.B. Over the counter medicines will only be administered for a max of 3 days) My child has not had a previous allergic reaction to the over the counter medicine described above. My child's name is clearly printed on the label.					
Parent Signature:					

TO BE COMPLETED BY THE EDUCATOR WHEN ADMINISTED

Name of medication	Last administered		To be administered (or circumstances to be administered)		Dosage to be administered	Method of administration	Medication administered		Dosage Administration	Method of administration	Name and signature of educator administering	Name and signature of witness
	Time	Date	Time	Date	ac ac	Σ	Time	Date	ă	Σ		