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### Medication Form – Doctors Authorisation for Long Term Medication (12 months)

Privacy Statement

The information requested by Council on this form may constitute personal information under the Privacy and Personal Information Protection Act 1998. Council is allowed to collect the information from you to consider this matter. Supplying this information is voluntary. However if you cannot or do not wish to provide the information, we may not be able to consider the matter. If you need further details, please contact the Privacy Officer, Campbelltown City Council, cnr Queen and Broughton Streets, Campbelltown. Please note that information provided may be shared with Department of Education (DEC), the Police, other relevant agencies and educators in accordance with applicable legislation.

#### Dear Doctor,

Please complete this form so that Campbelltown City Council's Education and Care Services can give medication to your patient. If the child's medical condition is contagious, he or she will not be able to attend the service.

### Only one medication is to be listed on this form. Please print clearly.

Child's full name			Date of birth								
Reason for medication											
Is this medication to treat condition?	a contagious	medical/health	Yes 🗌 N	o 🗌							
Name of medication (pleas	se print)										
Manner of administration											
Dosage		for a period of	Days/	Weeks (please circle)							
Time/s when medication s	Time/s when medication should be given (will not accept when necessary).										
Required timeframe between each dose											
Other specific details											
Doctor's name (please prir	nt)										
Doctor's signature			Date								
Doctor's phone number											
Please stamp with doctor's stamp											
Thank you for your co-operation, Campbelltown City Council											

# Medication Form – Doctors Authorisation for Long Term Medication (12 months)

This form is for long term medication authorised by a doctor for medication being given to a child each time the child attends the service, e.g. ADHD or regular asthma medication. No medication will be given without a doctor's authorisation. **Valid for 12 months.** 

## A CURRENT PHOTO OF CHILD HAS BEEN SUPPLIED (SCHOOL HOLIDAY CARE ONLY)

### Please note - medication must be in the original chemist prescription container.

I give permission for staff from Campbelltown City Council's Education and Care Services/my Family Day Care educator to administer the above medication as authorised by the Doctor on page 1.

Parent/caregiver's name

Parent/caregiver's signature		Date	
Name of staff member who rece	ived the medication		
form and verified details from par	ent		
Signature of staff member	who received the		
medication form and verified deta	ails from parent		
Expiry date of form (12 months ma	aximum)		
Expiry or use by date of medic	ation (whichever is		
sooner)			

Change in dosage times record (in exceptional circumstances)

Date	Reason	Last time given before coming to service	Required timeframe in between each dose	New time/s to be administered	Parent signature	Educator signature

Record of Administration		Signature								
		Educator who witnessed								
	Date of birth	Signature								
	Dat	Educator who administered								
		Time administered								
		Manner medication administered								
		Dosage given								
		Name of medication								
	Child's full name	Name of								
	Child's fı	Date								

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