I.A.S.C
Indooroopilly After School Care Association

Administration of Medication Form

Child's Name: _____

For Parent / Guardian to Complete							For Staff Members to Complete				
Date	Doctor's Name and Phone No.	Name of Medication	Dosage	Method of Administration	Time/s Required	Parent / Guardian Signature	Last time medicine was Given	Time Given	Person giving Medication Signature	Witness Signature	Notes

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