HUGS & KISSES EDUCARE CENTRE CC

1992/030768/23

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MEDICATION AUTHORISATION FORM 2014

Child's name and age:

CI	nild's group:	Kittens (Lee-Ann)	Fishes (Dorothy)		_	ddies bogo)	Tiggers (Candice)
1: Name of medication:		Was the medication prescribed by a doctor?	Please Tick: YES No	Quantity: Time:		Dosage:	
Indication for medication:		Or is it a medication available over the counter?	medication Tick: available over YES			-	our child must ation for:
Must the medication be stored in the refrigerator? Any side effects associated with the medication?			Plea	ase Tick:		YES	NO
Any p whilst							
Signed:			Date:		/	/ 201	14

2: Name			Was the medication	Please Tick:			Dosage:		
of		prescribed by a doctor?	YES	Quantity:					
medication:			No	Т	ïme:				
Indication			Or is it a medication	Please Tick:	Length of time that your child r receive the medication for:				
for medication:		available over the counter?	YES	Sta	t Date:				
			No	End Date:					
Must the medication be stored in the refrigerator?			e refrigerator?	Plea	Please Tick: YES			NO	
Any side effects associated with the medica			e medication?						
Any precautions that should be		e taken							
whilst	your	child is on the med	dication?						
Signed:			Date:		/ _	/ 2014			

3: Name		Was the medication	Please Tick:		Dosage:		
of medication:		prescribed by a doctor?	YES	Quantity:			
			No	Time:			
Indication		Or is it a medication available over the counter?	Please Tick:	Length of time that your child m receive the medication for:			
for medication:			YES	Start Date:			
			No	End Date:			
Must the medication be stored in the refrigerator?			Plea	Please Tick: YES			
Any side ef	fects associated with the	e medication?				-	
	precautions that should to your child is on the me						
Signed:			Date:	/	/ 2014		

4: Name			Was the medication prescribed by a doctor?	Please Tick:			Dosage:	
of		YES		Quantity:				
medication:				No	٦	Time:		
Indication			Or is it a medication	Please Tick:	Length of time that your child mu receive the medication for:			
for medication:		available over	Yes	Start Date:				
			the counter?	No	End Date:			
Must the medication be stored in the refrigerator?			Please Tick:			YES	NO	
Any side effects associated with the medication			e medication?					
Any precautions that should be t		e taken						
whilst	your	child is on the med	lication?					
Signed:			Date:		/ _	/ 2014		

5: Name			Was the medication prescribed by a doctor?	Please Tick:			Dosage:	
of		YES		Quantity:				
medication:		No		Tir	me:			
Indication			Or is it a medication	Please Tick:	Length of time that your child m receive the medication for:			
for medication:		available over the counter?	YES	Start Date:				
			No	End Date:				
Must the medication be stored in the refrigerator?			Plea	ise Tick	(:	YES	NO	
Any side effects associated with the medication			e medication?					
Any precautions that should be		e taken						
whilst	: your	child is on the med	lication?					
Signed:			Date:		/	/ 2014		