To be completed by the PRESCRIBING DOCTOR and the PARENT/GUARDIAN for child who requires supervision of medication at preschool or childcare.

This information is confidential and will be available only to supervising staff and emergency medical personnel.

**Two Wells Community Children’s Centre**
27a Gawler Road Two Wells 5501 ph:85202358

**ONGOING MEDICATION PLAN**

**CONFIDENTIAL**

(When Completed)

**To the Medical Practitioner**

*Please:*
- Complete all sections of this form.
- Schedule medication outside care/school hours wherever possible.
- Be specific: *As needed* is *not* sufficient direction for staff members, they need to know exactly when medication is required.
- Nominate the simplest method. For example, Oral or ‘puffer’ medication is much easier to arrange than a nebuliser.

**Please note that education and childcare workers:**
- accept only medication which has been ordered by a doctor and is provided in the original, fully labelled pharmacy container
- do not monitor the effects of medication as they have no training to do this
- are instructed to seek emergency medical assistance if concerned about a child’s/student’s behaviour following medication.

**To the Medical Practitioner**

*Please Note:*
- Young children (e.g. junior primary age) are generally supervised when they take their oral/puffer medication
- Wherever possible, safe self-management is encouraged.

Please advise if this child’s/student’s condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment (e.g. puffer and spacer).

**Medication Instructions**

(please print clearly)

<table>
<thead>
<tr>
<th>Medication name and form: (e.g. liquid, capsule, ointment)</th>
<th>Time (please indicate times relevant to preschool/childcare)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Early Morning</td>
</tr>
<tr>
<td></td>
<td>□ Mid-Morning</td>
</tr>
<tr>
<td></td>
<td>□ Middle of the day</td>
</tr>
<tr>
<td></td>
<td>□ Mid-afternoon</td>
</tr>
<tr>
<td></td>
<td>□ Evening</td>
</tr>
<tr>
<td></td>
<td>□ Other (please specify)</td>
</tr>
</tbody>
</table>

**To the Medical Practitioner**

*Please Note:*
- Young children (e.g. junior primary age) are generally supervised when they take their oral/puffer medication
- Wherever possible, safe self-management is encouraged.

Please advise if this child’s/student’s condition creates any difficulties with self-management; for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment (e.g. puffer and spacer).

**Authorisation and Release**

**Medical Practitioners**

*Name:* [ ]

*Address:* [ ]

*Signature:* [ ]

*Date:* [ ]

**Parent/Guardian Please Read:**

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to education/childcare staff and emergency medical personnel.

**Signature:** [ ]

**Date:** [ ]

**Office Use Only**

*Sighted by:* [ ]

*Name in block letters:* [ ]

*Signature:* [ ]

*Date:* [ ]