Medication Consent Form

CHILD'S NAME:____

CHILD'S CONDITION FOR ADMINISTRATING MEDICATION (please check one):

_________ Cold _________ Ear Infection _________ Injury

_________ Rash _________ Sore Throat _________ Other: ______________

NAME OF MEDICATION: ____

________ Prescription _______ Non-prescriptions _____ Doctor's approval required

NAME OF DOCTOR WHO PRESCRIBED: __________________________________

AMOUNT TO BE ADMINISTERED: _______________________________________

TIME (S) MEDICATION TO BE ADMINISTERED: ___________________________

DATES MEDICATION TO BE ADMINISTERED: ____________________________

REFRIGERATION NECESSARY: ________YES ________NO

POSSIBLE ADVERSE REACTIONS: _______________________________________

I authorize the administration of medication to my child.

PARENT SIGNATURE: ____________________________________ DATE: ___________

Dates Administration	Time (s) Administration	Adverse Reactions Observed	Staff Member's Initials

- Is all of the above information complete?
- Is medicine in the original container with the prescription label on it?
- Is the child's name on the container?
- Is the date of the prescription current?
- Is the name of the drug, dose, and administration schedule given on the label the same as the instructions given by the parent?
- Has the medication been placed out of reach of the child?
- This form is only good for two weeks and must then be resigned by the parent.