MEDICATION CONSENT FORM

Name of Child:_____

Name of medication:_____

Please (check) one of the following: Prescription:_____ Oral/Non-Prescription:_____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/broken skin)**_____

My child has previously taken this medication_____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage:_____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects:_____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____Date_____

I,_____, (parent or guardian) gives permission
(print name)
to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____Date_____
For topical, non-prescription **NOT** applied to open wound/broken skin **(parent signature only)**