



NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**MEDICATION CONSENT FORM**  
CHILD DAY CARE PROGRAMS

**PARENT COMPLETE THIS SECTION (#19 - #23)**

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)*  Yes  N/A  No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: \_\_\_\_\_

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name)*:

21. Parent's Name *(please print)*:

22. Date Authorized:

23. Parent's Signature:

**X**

**CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)**

24. Program Name:

Children's Nest Early Childhood Ctr

25. Facility ID Number:

314840DCC -Merrick

26. Program Telephone Number:

516 867 7404

27. I have verified that (#1 - #23) and if applicable, (#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:

29. Date Received from Parent:

30. Staff Signature:

**X**

**ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)**

31. I, parent, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

**X**

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)**

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: \_\_\_\_\_

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

**X**