LearnStar
After School Programs

Medication Consent and Administration of Medication Record

Name of Child: _____

Date of Birth: _____

Name of Learnstar Program Enrolled in: _____

Part 1: Information (to be completed by parent/guardian)

Date medication prescribed: _____ For how long: _____

Name of Prescribing Physician: _____

Physician's Telephone: _____

Reason for Medication: _____

Name of Medication: _____

Dose: _____

The child has received _____ doses at home

Did the child have any reaction to this medication? YES NO

If yes, please describe

_____

_____

Any special instruction for medication (such as take with food, 1 hour before eating, etc).

_____

_____

LearnStar
After School Programs

I _____ (parent/guardian) give permission for my child _____ (*child's name*) to be given medication according to the instructions stated above. I have explained when and how to give this medication and understand that I will be contacted if my child shows unusual symptoms.

Parent/Guardian Name: _____

Signature of Parent/Guardian: _____

Date: _____

LearnStar
After School Programs

Part 2: Administration of Medication Record

Write the date and times below the medication was administered and sign you initials in the appropriate boxes.

Date (yy/mm/dd)	Time	Amount/ Dose	Caregiver	Witness	Time

Provider Comments: _____

_____

_____

Observations	Description	Actions
Side Effects		
Spillage/damage of medication		
Refusal to take medication		