Medication Consent Form

Required if the child has emergency medication or medication is needed during our program.

Child's First & Last Name: ____ DOB: _____________

Medication Name:____

This medication is (Please check one):

- ❏ Prescription
- ❏ Oral/non-prescription
- ❏ Unanticipated non-prescription for mild symptoms
- ❏ Topical non-prescription (applied to open wound/broken skin)

My Child Has (Please check one):

- ❏ Previously taken this medication
- ❏ NOT previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication in accordance with their individual health care plan.

Medication Information

Dosage	
Date(s) medication to be given	
Times Medication to be given	
Reason(s) for Medication	
Possible side effects	
Directions for storage	

____ ___________________________ _________________

Prescribing Health Care Practitioner Signature* Printed Name Date

By signing below, I authorize educator(s) to administer medication to my child as indicated above.

____ ___________________________ _________________

Guardian Signature Printed Name Date

**For topical, non-prescription NOT applied to open wound/broken skin, only a parent signature is required.*