Child Matters Incorporated

**Medication Information and Consent Form**

Name of Child:

Date of Birth:

**Medication 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:

Dosage:

Times to give medication:

The child received \_\_\_\_\_\_ (number) of doses at home.

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

If YES, describe the reaction:

Special consideration for this medication (e.g., taken with meals, 1 hour before meals):

**Medication Administration Consent:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian Name) give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (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 any unusual symptoms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Centre Staff Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Centre Staff Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date