**Arizona Department of Health Services**
**Bureau of Child Care Licensing**

# MEDICATION CONSENT FORM

| First & Last Name of **CHILD**: | | | |
|---|---|---|---|
| Type/Name of Medication: | Prescription #: | Dosage**:** | Route (method)*: |
| Start date: | End Date: | Times & frequency: | |
| REASON: | | | |
| **I give permission for the administration of the medication, according to the instructions listed, to the child listed above.** | | | |
| Date of authorization: | Signature (parent/guardian): | | |

**POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:**

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## * Injections: Attach health care provider's written authorization.

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| FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION: | YES | NO |
|---|---|---|
| **Is the medication consent form complete?** | ☐ | ☐ |
| **Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?** | ☐ | ☐ |
| **Is the full name of the child on the container?** | ☐ | ☐ |
| **Is the prescription or over-the-counter medication current?** | ☐ | ☐ |
| **Is the dose, name of drug, frequency of administration given on label consistent with instructions above?** | ☐ | ☐ |

**Staff initials:**_____

***Please use the second page to document administration of the medication.***

***Name of Child:***

| DATE | NAME OF MEDICATION | RX# | DOSE | TIME | FULL SIGNATURE of AUTHORIZED STAFF PERSON |
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