MEDICATION CONSENT FORM

Name of Child	Date	Room_	
Name of Medication		Date Prescribed	1
FOR PARENT TO COMPLETE:			
I, give (Parent or Guardian)	permission to		
(Parent or Guardian)	(Nar	ne of authorized d	lay care staff)
to administer of (dose) (name of	to п	ry child	
(dose) (name o	of medication)	(nai	me of child)
at approximately:(time(s) dose due)	on	for	for modication)
Possible side effects to watch for with this med	dication include:		
The name and phone number of the prescribi	ng physician:		
	S1 75		
	-		
	Signature of	Parent	Date
FOR STAFF TO COMPLETE:	20 12	(Place a "/" on o	ne of the boxes) NO
	28	123	NO
is the permission form (above) completed?			
is the medication in a safety cap container?			
Is the original prescription label on the medication	on containers?		
is the name of child given above on the contain	er?		
Is the date on prescription current (within the mo within the expiration date for medications which within the year otherwise?			
is the dose, name of drug, frequency of administ consistent with parental instructions given above			
MEDICATION CAN BE ADMINISTERED ONLY IF T	HE ANSWERS TO ALL OU	ESTIONS ABOVE	ARF "YES"

MEDICATION CAN BE ADMINISTERED	ONLY IF THE ANSWERS TO ALL	QUESTIONS ABOVE ARE "YES".

Date to be given	Time	ne Signature of Teacher Dispensing Medication	
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