

MEDICATION CONSENT FORM

(To be filled out by child's physician)

Name of Child: _____ Date: _____

Name of Medication: _____

Prescription Non-Prescription

Method of administration: _____

Dosage: _____ Strength: _____

Date(s) to be given: _____

Time(s) to be given: _____

Reason for taking medication: _____

Possible side effects: _____

Directions for storage: _____

Name and number of prescribing physician: _____

Physician's Signature: _____

Date: _____

(To be filled out by parent/guardian)

I, _____ (parent/guardian) give permission to authorized staff member(s) to administer medication to my child as indicated above.

Parent/Guardian signature: _____

Date: _____