

## ADMINISTRATION OF MEDICATION CONSENT FORM

CHILD'S NAME:	
PHYSICIAN'S NAME:	PHONE:
PHARMACY NAME:	PHONE:
MEDICATION:	PRESCRIPTION #:
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN ADMINISTERED TO THIS CHILD PREVIOUSLY? <input type="checkbox"/> YES <input type="checkbox"/> NO  IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO
TIMES TO BE GIVEN BY PARENT:	
TIMES TO BE GIVEN BY CARE PROVIDER:	
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?	

*I hereby give permission and authorize \_\_\_\_\_ to administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.*

\_\_\_\_\_  
**Signature of Parent/Guardian**                      **Date**                      **Phone**

### CAREGIVER'S ADMINISTRATION RECORD:

DATE:	TIME GIVEN:	AMOUNT GIVEN:	ADMINISTERED BY: