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? ☐ YES ☐ NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? ☐ YES ☐ 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: