ADMINISTRATION OF MEDICATION CONSENT FORM

Name of child: _____

Name of medication: _____
Prescription: _____ Non-Prescription: _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Name and phone number of prescribing physician:

_____

Directions for storage: _____

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

_____ _____

Parent/Guardian Signature _____

Date _____