

# MEDICATION CONSENT FORM

First & Last Name of CHILD:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start Date:	End Date:	Times & Frequency:	
Reason:			

I give permission for the administration of the medication, according to the instructions listed, to the child listed above.

Date of Authorization:	Signature (parent/guardian):
------------------------	------------------------------

**POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:**

---



---

**FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:**

YES    NO

- Is the medication consent form complete?
- Is the original prescription label on the medication container or prepackages and labeled for use by the manufacturer?
- Is the full name of the child on the container?
- Is the medication label completed and applied to container?
- Is the prescription or over the counter medication current?
- For all over the counter medications: is there a doctor's note that states the dates, times and reason to administer?
- Is the dose, name of drug, frequency of administration given on label consistent with instructions above?

**PLEASE USE THE SECOND PAGE TO DOCUMENT ADMINISTRATION OF THE MEDICATION**

