

MEDICATION ADMINISTRATION AND CONSENT FORM

Child's Name: _____

THIS SECTION TO BE COMPLETED BY PARENT:

Date	Parent's Signature	Name of Medication/ Possible Side Effects to Watch For	To Be Given	Amount Each Dose/ by Mouth, Nose, Ear	Last Dose Given	Duration of Medication	Refrigeration

I give permission to administer medication to my child as stated below:

Safety Check:

1. Child resistant container
2. Original prescription or manufacturer's label and physician's direction for use (phone or written)
3. Name of child on container
4. Current date on prescription/expiration label
5. Name and phone number of licensed health professional who ordered medication on container

Safety Check?	Time Given	Staff Initials	Date	Reaction/Notes