



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

Parent/Guardian Signature

Date

Doctor's Signature (for non-prescription medication) _____