Medication Consent Form

Date: _____

Child's Name _____ Classroom _____

Name of Medication _____

Is this medication over the counter _____ Prescription _____

Does it require refrigeration? Yes No

For what condition is the child taking this medication?

_____

At what times should medication be administered? (CIRCLE ONE)

12pm 4pm other _____ (Dr. note required)

Dates medication is to be administered:

Beginning _____ Ending _____

Please list the instructions for administering this medication (i.e. dosage, frequency, time of day, with food, etc.)

_____

_____

Please note: Over the counter medications will **not** be administered for more than 5 days without a note from the physician. All medications must:

- be in the original container
- be prescribed to the child it is being administered to
- not be expired
- be administered according to instructions

Parent Signature _____

OFFICE USE ONLY: Medication administered at (time and date) _____

_____

_____