

MEDICATION CONSENT FORM

**For Parent To Complete:**

I \_\_\_\_\_ give permission to the All Day \_\_\_\_\_ staff to administer  
 (Parent/guardian name) (Room)  
 Of \_\_\_\_\_  
 (Dose) (Full name of medication)  
 Prescribed on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ for \_\_\_\_\_  
 (Mont/Day/Year) (Child's full name)  
 At \_\_\_\_\_ begin on \_\_\_\_ / \_\_\_\_ ending \_\_\_\_ / \_\_\_\_ for \_\_\_\_\_  
 (Time(s) dose due) (Month/Day/Year) (Reason for meds)

Possible side effects from medication \_\_\_\_\_

- Does medication need to be refrigerated? (Circle one)  
YES NO
- Is this a prescription medicine? YES NO

Name and number of prescribing physician: \_\_\_\_\_  
 (Name) (Phone)

SIGNATURE OF PARENT: \_\_\_\_\_  
 (Name) (Date)

**For Staff To Complete:**

- Is the permission form (above) completed in its entirety? (Circle one)  
YES NO
- Has medication container been properly stored? YES NO
- Is the medication in a childproof safety cap container? YES NO
- Does the child's name appear on the container? YES NO
- Is the date on the prescription current within the month for antibiotics and within the expiration date for medications (otherwise, within a year of the date labeled)? YES NO
- Is the dose, name of drug, frequency of administration given on the label consistent with parental instructions listed above? YES NO

**MEDICATION ADMINISTRATION RECORD**

*STAFF - REMEMBER EACH DATE MUST BE ACCOUNTED FOR AND ALL DATES OF ADMINISTRATION MUST BE LISTED AT TIME OF CONSENT.*

Date	Time Given	Dose	Staff Signature

*Continued on back*

