MEDICATION CONSENT

Name of Child _____ Date of Birth _____

Information to be completed by guardian(s)

Date medication prescribed: _____ For how long: _____

Name of prescribing physician: _____

Physician's telephone: _____

Reason for medication: _____

_____

Name of medication: _____ Dose: _____

How is it given? _____

Time(s) to give medication: _____ _____ _____

The child received _____ (number) of doses at home.

Did the child have any reaction to the medication? Yes _____ No _____ If yes, describe:

_____

I, _____ (guardian) give permission for my child _____ (child's name) to be given medication according to the instructions stated above. I have explained when and how to give this medication and understand that I will be contacted if my child shows any unusual symptoms.

_____ _____

Guardian's signature Date