MEDICATION CONSENT FORM

606 CMR 7.11(2)(b)

Name of child (Required): _____

Name of medication (Required): _____

Please select one of the following (Required):
(Select only one option)

- ☐ Prescription
- ☐ Oral/Non-Prescription

Check any of the following (if they apply):

- ☐ Unanticipated Non-Prescription for mild symptoms
- ☐ Topical Non-Prescription (applied to open wound/ broken skin)

My child has previously taken this medication (Required):
(Select only one option)

- ☐ YES
- ☐ NO

☐ My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan.

Dosage (Required): _____

Date(s) medication to be given (Required): _____

Times medication to be given (Required): _____

Reasons for medication: _____

Possible side effects: _____

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Directions for storage (Required): _____

Name of the prescribing health care practitioner (Required): _____

Phone number of the prescribing health care practitioner (Required): ( ) -

Child's Health Care Practitioner Signature: _____

Date: _____

I, the undersigned parent or guardian, give permission for educators to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Print Name (Required): _____

Parent/Guardian Signature (Required): _____

For topical, non-prescription NOT applied to open wound / broken skin (parent signature only)

Date (Required): _____