Medication Consent Form

- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-#18 for medication to be administered more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-#22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. **CHILD's first and last name:**	2. Date of birth:	3. Child's known allergies:
4. **Name of MEDICATION** (including strength):	5. **Amount/DOSAGE to be given**:	6. **ROUTE of administration**:

7A. **FREQUENCY to administer**: __________________ or **Specific TIME(s)** (e.g. 1p.m.): ______________________

Parent's signature approving Specific Time(s)______________________

OR

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: □ See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should be taken if side effects are noted:

□ Contact parent
□ Other (describe):
□ Contact prescriber at phone number provided below

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) ____

11. **Reason the child is taking the medication** (unless confidential by law): __________________________________

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
□ No □Yes If you checked yes, complete #25 and #27 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?
□ No □ Yes If you checked yes, complete #26 and #27 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid):
16. **Prescriber's name** (please print):	17. **Prescriber's telephone number**:

18. **Licensed authorized prescriber's signature**:

Required for long-term medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

This is a double-sided form

Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to (child's name) .	
20. Parent or legal guardian's name (please print):	21. Date authorized:
22. Parent or legal guardian's signature:	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on ______________________________ (date) . Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE:______________________ By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:	29. Facility Phone Number:
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized provider's name (please print):	31. Date received from parent:
32. Authorized provider's signature:	

This is a double-sided form