Medication Consent and Administration of Medication Record

Name of Child: _____ Date of Birth: _____
(yy/mm/dd)

Part I: Information (to be completed by parents)

Date medication prescribed: _____ For how long? _____

Name of prescribing physician: _____

Physician's telephone: _____

Reason for medication: _____

Name of medication: _____ Dose: _____

Times to give medication: _____

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

Did the child have any reaction to this medication? YES NO If yes, describe:

_____

Special consideration for this medication (e.g., taken with meals, 1 hour before meals):

_____

I, _____ (parent) 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.

_____ _____
Parent's signature Date