## MEDICATION CONSENT FORM

Name of child:	
Prescription: N	Non-Prescription:
Dosage:	
Date(s) medication to be given:	
Times medication to be given:	
Reasons for medication:	
Possible side effects:	
Name and phone number of prescribing p	physician:
Directions for storage:	
I,	, (parent or guardian) give permission
	nister medication to my child as indicated above.
Parent/Guardian Signature	Date
Doctor's Signature	
(fo	or non-prescription medication)

## **MEDICATION ADMINISTRATION RECORD**

Date	Time	Dosage	Staff Signature