MEDICATION CONSENT FORM
102 CMR 7.05 (2) (c)

Name of child: ______________________________

Name of medication: ______________________________

Prescription: _______ 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 physician:

____

Directions for storage: ______________________________

I, ______________________________ (parent or guardian) give permission to authorized staff member(s) to administer medication to my child as indicated above.

____
Parent / Guardian Signature

____
Date

____
Doctor's Signature (for non-prescription medication)

____
Date

MEDICATION ADMINISTRATION RECORD

Day	Date	Dose	Staff Signature

* All medications must be Presented in original Container*