Medication Consent Form

Child	Date

Medication* (SEE BELOW FOR MEDICATIONS REQUIRING WRITTEN PERMISSION BY HEALTH CARE PROVIDER)		
Dosage	**Time(s) to be given**	**Date(s) to be given***

Symptoms that necessitate administration if medication is to be given as needed or any special instructions
Signature of Parent or Guardian

HEALTH CARE PROVIDER'S WRITTEN PERMISSION REQUIRED FOR

- Medication whose instructions are not consistent with directions on the medication label (including but not limited to age and special health conditions)
- Medication to be given 10 days or more (except for over the counter ointments, creams, and lotions)
- Epi Pens, Inhalers, and Nebulizers intended for emergency use

Name of Health Care Provider_____Phone:_____

Signature of Health Care Provider:_____Date:_____

Date	Time	Medication	Dose	Comments (Errors, Reactions)	Given By