THE CHILDREN'S WORKSHOP

MEDICATION **CONSENT**

REV. 2020

Name of child: ____

Name of medication: ____

PLEASE SELECT ONE OF THE FOLLOWING:

_____ Prescription

_____ Oral/Non-Prescription

_____ Unanticipated Non-Prescription for mild symptoms

_____ Topical, Non-Prescription - applied to open wound/ broken skin

_____ Topical, Non-Prescription - NOT applied to open wound / broken skin

PLEASE SELECT ONE OF THE FOLLOWING:

_____ My child has previously taken this medication

_____ My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan.

Dosage: ____

Date(s) medication is to be given: ______________________________

Time(s) medication is to be given: ______________________________

Reason(s) for medication: ____

Possible side effects: ____

Directions for storage: ____

Name of the prescribing health care practitioner: ____

Phone number of the prescribing health care practitioner: ______________________________________

Child's Health Care Practitioner Signature: ___________________________________ **Date:** __________

I, ______________________________________, (parent or guardian) gives permission to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature: ____ **Date:** __________

(Only a parent signature is needed for Topical, Non-Prescription - NOT applied to open wound / broken skin)