Commonwealth Of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please check one of the following: Prescription: [ ] Oral/Non-Prescription: [ ]

Topical Non-Prescription **(applied to wound/broken skin)** [ ]

My child has previously taken this medication _____ (indicate yes or no).

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for the staff to give this medication to my child in accordance with his/her individual health care plan _____ (indicate yes or no).

Dosage: _____

Date(s) Medication to be given: _____

Times mediation to be given: _____

Reasons for medication: _____

Possible side effects of medication: _____

Directions for storage of medication: _____

Name & Address of prescribing health care practitioner: _____

_____

Child's Health Care Practitioner's Signature: _____ Date: _____

I, _____, (parent or guardian) give permission to (print name)

educator(s) to administer medication to my child as indicated above.

Parent/ Guardian Signature: _____ Date: _____
(For topical, non-prescription **NOT** applied to open wound / broken skin **(parent signature only)**