Kiddie University

YOUR NEIGHBORHOOD PRESCHOOL

MEDICATION CONSENT FORM

First & Last Name of Child:			
Type/Name of Medication		Dosage	☐ Refrigerate
Start Date	End Date	Times & frequency	
Reason			
Method/Special Instructions			
Possible Side Effects			
Date of authorization:	Name of Physician:		
Print Parent/Guardian Name:	Parent/Guardian Signature:		

Attach health care provider's written authorization.

FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	Staff Name	Date	
Is the medication consent form complete?		YES	NO
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?		YES	NO
Is the full name of the child on the container?		YES	NO
Is the prescription or over-the-counter medication current?		YES	NO
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?		YES	NO
Staff Signature			

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Medication Log

Name of Child:

DATE	NAME OF MEDICATION	DOSE	TIME	FULL SIGNATURE of Staff Member

I received information on administration of medication and any unused medication was returned to me.

Parent signature:	Date: