Arizona Department of Health Services
Bureau of Child Care Licensing

MEDICATION CONSENT FORM

First & Last Name of CHILD:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of authorization:	Signature (parent/guardian):		

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

* Injections: Attach health care provider's written authorization.

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

Staff initials:_____

Please use the second page to document administration of the medication.

Name of Child:

DATE	NAME OF MEDICATION	RX#	DOSE	TIME