East Valley JCC
Early Childhood Learning Center

Arizona Deoartment 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:

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 prepackages and labeled for use by the manufacturer?
☐	☐	Is the full name of the child on the container?
☐	☐	Is the medication label completed and applied to container?
☐	☐	Is the prescription or over the counter medication current?
☐	☐	For all over the counter medications: is there a doctor's note that states the dates, times and reason to administer?
☐	☐	Is the dose, name of drug, frequency of administration given on label consistent with instructions above?

PLEASE USE THE SECOND PAGE TO DOCUMENT ADMINISTRATION OF THE MEDICATION

NAME OF CHILD:

Date	Name of Medication	RX#	Dose	Time	Full Signature of Authorized Staff Person