

Child's Classroom _____

Parent's Consent for Medication

Child's Name _____ Date of Birth _____

Medication to be administered _____

Route of administration _____

(*Oral*=by mouth, *topical*=placed on skin, *eye drops*=placed in the eyes, *ear drops*=placed in the ears, *nose drops*=placed in the nostrils)

Dosage _____

(Must have Doctors Note if different than bottle directions or prescription label.)

All medications must be in original container and/or have prescription label)

Time _____

Time _____

Special Instructions: _____

(Medications are given at 11:00 a.m. & 3:00 p.m.)

Reason _____

Start date _____

End date _____

Parent Signature _____ Phone # _____

Any know medication allergies (please list) _____

Doctors Name _____ Phone Number _____

Pharmacy _____ Phone Number _____

All Medication Must Be Labeled