S.E.E.K. Early Learning Center

Medication Consent Form

First and Last Name of **CHILD**:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start Date:	End Date:	Times & Frequency:	
Reason:			

Possible side effects to watch for with this medication:

_____
_____
_____
___

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

I give permission for the administration of the medication, according to the instructions listed, to the child listed above.

_____

Legal Guardian Printed Name

_____

Legal Guardian Signature Date

_____

S.E.E.K. Representative Date

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 the 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.