

NAME OF THE AGENCY, NAME OF AFTER-SCHOOL PROGRAM, SCHOOL

Medication Consent & Log of Administration

- The parent/guardian must see that all areas of the first page are filled out.
- One form must be completed for each medication the child is on. Multiple medications cannot be listed.

Child's First and Last Name:	Date of Birth:	Child's Known Allergies:
CBO:	School:	After-School Program Telephone Number:

Authorized prescriber to complete

Licensed Authorized Prescriber's Name:		Licensed Authorized Prescriber's Telephone Number:
Name of Medication (including strength if applicable):	Amount/Dosage to be Given:	Route of Administration:
Date to be Discontinued or Length of Time in Days to be Given (up to 6 months):	Time(s) to be Administered (for non PRN medication):	Refrigeration Required: YES <input type="checkbox"/> NO <input type="checkbox"/>
Reason for Taking Medication (unless confidential by law):		
Possible Side Effects:	What Action to Take if Side Effects are Noted:	
Special Instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered)		
Identify the Symptoms That Will Necessitate Administration of Medication: (complete this section for as needed (PRN) medication only)		

Medication Consent/Authorization

I, _____ authorize _____ to administer the medication listed above to _____.
(Parent/Legal Guardian) (After School Provider) (Child's Name)

Required Signatures

Parent or Legal Guardian's Name (please print) Parent or Legal Guardian's Signature Date

Name of Provider Who Received This Statement (please print) Provider Signature Date Received from Parent

Signature Required for All Medication Instructions

Licensed Authorized Prescriber's Name (please print) Licensed Authorized Prescriber's Signature Date

Medication Discontinuation Authorization (complete to revoke consent for provider to administer medication)

I, _____ request that the medication listed above be discontinued effective _____.
(Parent/Legal Guardian) (Medication Discontinue Date)

Parent or Legal Guardian's Name (please print) Parent or Legal Guardian's Signature Date

