



Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If section number 7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm): _____	
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name)	
21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #29)

24. Provider/Facility name:	25. Facility telephone number:
26. I have verified that #1-#23 and if applicable, #32-#35 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.	
27. Authorized child care provider's name (please print):	28. Date received from parent:
29. Authorized child care provider's signature:	

ONLY COMPLETE THIS SECTION (#30 - #31) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

30. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
31. Parent/legal guardian's signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#32 - #35)

32. Describe any additional training, procedures, or competencies the child day program staff will need to care for this child. _____ _____ _____
33. Licensed Authorized Prescriber's signature:
34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time, or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order: _____
35. Licensed Authorized Prescriber's signature:

This is a double-sided form