# Medication Consent

**Child's Name:** ______________________ **Date of Birth:** __________ **Age:** ______

Reason for medication: ______________________ Date initiated: __________

Name of medication: ______________________

Time to be administered: ______________________ Dosage: __________

How is the medication to be stored: ______________________

How is the medication to be administered: ______________________

Medication Start date: ______________________ Stop date: __________

Expected side effects: ______________________

Comments: ______________________

Prescription and non-prescription medications may only be administered in accordance with instructions on the label.

I authorize Country Dawn staff members to administer the medication listed above. I understand that this authorization is to remain in effect only for the number of days stated on the prescription medication bottle or until the recommended stop date on non-prescription medication.

**Parent / Guardian signature:** ______________________ **Date:** __________

## Long Term Medication Physician Consent

I authorize the above named child to have the medication listed above until further notice. They are receiving ongoing treatment for a chronic or life threatening illness.

**Physician signature:** ______________________ **Date:** __________

| Date | Time | Medication | Dose | Given By |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Date | Time | Medication | Dose | Given By |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |