

Medication Consent Form
102 CMR 7.05(2)(c)

Name of Child: _____	
Name of Medication: _____	
<input type="radio"/> Prescription	<input type="radio"/> Non-Prescription

Dosage: _____
Date(s) to be given: _____
Times medication to be given: _____
Reasons for medication: _____
Possible Side effects: _____

Prescribing physician name and phone number: _____
Directions for storage: _____ _____

I, _____ (parent or guardian), give permission to authorize staff members to administer medication to my child as indicated above.

Parent/Guardian Signature

Date

Prescribing Physicians's Signature
(for non-prescription medication or if prescription medication does not have label attached)