CLINTON CO-OPERATIVE CHILDCARE CENTRE INC.

MEDICATION CONSENT FORM

Parents fill in bold type areas only and if not complete, medication will not be given

Child's Name: _____ Parent's Name: _____

Start Date: _____ Finish Date: _____ Expiry Date: _____

Diagnosis: _____ Medication: _____

Time to be Administered: _____ Dosage: _____ Max Dosage Per Day: _____

Possible Reactions to Medication: _____

Refrigerated: Yes No

Time last administered at time of consent: _____

Parent's Signature: _____ Date: _____

Location of Medication: _____

Date	**Parent Signature**	Amount Given	Time Given	Staff Names	Staff Signatures

Staff check off the following and sign when accepting medication:

Name on Medication	Original Bottle	Dosage Amount on Box/Label	Start and Finish Date	Stored as per Instructions	Returned to parent When finished

Staff Signature: _____

Supervisor Signature: _____

Revised December 2018