CLINTON CO-OPERATIVE CHILDCARE CENTRE INC.

ON GOING 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: _____

Medication _____Expiry Date: (if noted on medication) _____

Diagnosis: _____

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

Refrigerated: Yes No

Location of Medication: _____

Possible reactions to Medication: _____

NOTES: _____

Possible Signs and Symptoms of the Child requiring the identified medications:

Signs: _____

Symptoms: _____

I_____ give permission for the childcare staff to administer the medication listed above between the dates starting_____ and ending_____.

I give my child, _____ permission to carry his/her own medication.

Parent's Signature: _____ Date: _____

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

*To be completed by two Childcare Centre staff each time medication is administered

Date	Medication	Amount Given	Time Given	Staff Signature	Notes