





**Written Medication Consent Form**

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

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?)  Yes  N/A  No  
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 - #30)**

24. Provider/Facility name: \_\_\_\_\_ 25. Facility telephone number: \_\_\_\_\_ 26. (leave blank)

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.

28. Authorized child care provider's name (please print): \_\_\_\_\_ 29. Date received from parent: \_\_\_\_\_

30. Authorized child care provider's signature: \_\_\_\_\_

**ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15**

31. 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.

32. Parent or Legal Guardian's Signature: \_\_\_\_\_

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)**

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. \_\_\_\_\_

34. Licensed Authorized Prescriber's Signature: \_\_\_\_\_

35. 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.  
DATE: \_\_\_\_\_

By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature: \_\_\_\_\_