Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child:

_____ Name of

medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)_____**

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage:

_____

Date(s) medication to be given:

_____

Times medication to be given:

_____ Reasons for medication:

_____ Possible side effects:

_____ Directions for

storage: _____

Name and phone number of the prescribing health care practitioner:

_____

__ Child's Health Care Practitioner Signature

_____Date_____

I, _____, (parent or guardian) gives permission (print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____ For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**