

**Arizona Department of Health Services  
Office of Child Care Licensing**

**MEDICATION CONSENT FORM**

First & Last Name of CHILD:			
Type of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of authorization:		Signature (parent/guardian):	

**POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:**

---



---

**\* Injections: Attach health care provider's written authorization.**

\*\*\*\*\*

FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	<input type="checkbox"/>	<input type="checkbox"/>
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?	<input type="checkbox"/>	<input type="checkbox"/>
Is the full name of the child on the container?	<input type="checkbox"/>	<input type="checkbox"/>
Is the prescription or over-the-counter medication current?	<input type="checkbox"/>	<input type="checkbox"/>
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?	<input type="checkbox"/>	<input type="checkbox"/>
Staff initials: _____		

***Please use the second page to document administration of the medication.***

