

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 Check one of the following: Prescription: _____ 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 NOT 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 prescribing health care practitioner:

I _____ (Parent or Guardian) give permission to

(Print Name)

authorize Guild of St. Agnes Staff 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**)