Consent to Administer Medication
Short Term or Temporary

To be completed by the Parent(s) / Guardian(s)

Please fill out a separate form for every medication to be administered

Child's Name: _____

Medication to be administered: _____

Dates to be given: Start Date: _____ Finish Date: _____
(Max. 2 Weeks.)

Amount to be given: _____

Exact Times to be given: _____

Special Instruction: (e.g. taken with food) _____

_____

Medications Given at Home: _____ Time: _____

_____ Time: _____

_____ _____
Signature of Parent(s) / Guardian(s) Date

Medication Record

Child's Name: _____

Date	Medication	Dosage	Time	Staff Signature	First Aid Certificate