



# 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