MEDFIELD AFTERSCHOOL PROGRAM
www.medfieldafterschoolprogram.com

GENERAL MEDICATION CONSENT FORM

To be filled out on the child's last day.
Date returned:_____

Parent/Guardian Signature:

USE THIS FORM FOR: Prescription & non-prescription medications that are NOT necessary for a severe allergy or a chronic condition. (examples: ibuprofen, antibiotics, etc.)

(only one medication per form)

Name of Child: _____ Name of Medication:_____

☐ Prescription
☐ Non-Prescription *(A PHYSICIAN'S SIGNATURE is REQUIRED if the medication is NOT a prescription OR is for a chronic condition requiring training on the medical condition or administration of required medication*

Reasons for medication: _____ Possible side effects:_____

Dosage: _____ Date(s) to be given: _____ Time(s) to be given: _____ (be specific – do not just write as needed)

Date of 1st dose* _____ Type of medication ☐ Liquid ☐ Pill (# Pills *(if prescription)* ____) ☐ Inhaler ☐ Other (_____)

**MAP is not allowed to administer the 1st dose of a medication unless it is an emergency medication (example: EPI Pen)*

Storage directions:_____

Does the child have the same medication, or other medications at school, that may be administered before they arrive at MAP and that would require the MAP staff to know when it was last taken? ____ **NO** ____ **YES** (if yes, answer the follow up question)

If yes, do you give your child's school nurse permission to contact MAP and/or for MAP to contact the nurse to see if any such medication was administered during the child's school day? ____ **NO** ____ **YES**

I, _____, the parent/guardian, will provide the MAP Staff with directions & training that specifically addresses the child's allergy, medication(s), and other treatment needs and give permission for MAP to administer the above treatment, including the administration of the medications specified.

If non-prescription: Doctor's/Provider's Signature: _____ **Date:** _____

Print Name of Doctor/Provider: _____ **Office Phone:** _____

Parent's/Guardian's Signature: _____ **Date:** _____

Medication Administration Record

FOR STAFF USE: ☐ Medication Consent form complete ☐ Original prescription label on the medicine container ☐ # Pills *(if prescription)* ____

☐ Name of the child on the container ☐ Date on prescription current ☐ Expiration Date _____

☐ Dose, name of drug, frequency of administration on the label consistent with instructions

CHILD'S NAME: _____ **MEDICATION:** _____

Date	Time	Medication	Dose	Route	Staff Signature	Misdoses Errors	Child Refusal (✓)

**If child refused medication, explain why and attach to administration record.*

This record must be maintained in the child's file when complete

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