



**MEDFIELD AFTERSCHOOL PROGRAM**  
[www.medfieldafterschoolprogram.com](http://www.medfieldafterschoolprogram.com)  
**GENERAL MEDICATION CONSENT FORM**

**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 1<sup>st</sup> dose\* \_\_\_\_\_ Type of medication:  Liquid  Pill (# Pills (if prescription) \_\_\_\_\_)  Inhaler  Other (\_\_\_\_\_)

\*MAP is not allowed to administer the 1<sup>st</sup> 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*

