MEDFIELD AFTERSCHOOL PROGRAM
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 for a severe allergy or a chronic condition. One medication per form and must be in original box/container. (Ex. Antibiotics, ibuprofen, etc)

Name of Child: _____ Name of Medication:_____

☐ Prescription
☐ Non-Prescription *(A Licensed Health Care Practitioner'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: epinephrine)*

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? ☐ **YES** ☐ **NO** **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? ☐ **YES** ☐ **NO**

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

REQUIRED IF NON-PRESCRIPTION

Licensed Health Care Practitioner *(please print)***:** _____

Licensed Health Care Practitioner Authorization/Signature: _____**Date:** _____

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

COMPLETED BY MAP STAFF: MEDICATION ADMINISTRATION RECORD

☐ Who trained the staff: _____ ☐ Medication Consent Form Completed
☐ Original prescription label on the medicine container ☐ Name of the child on the container
☐ Date on prescription current (good for 1 year from date prescription filled) ☐ Expiration Date _____
☐ Dose, name of drug, frequency of administration given on the label match parent/guardian instructions
☐ 5 rights addressed (right child, right medication, right dose, right route & right time)

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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