Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM  606 CMR 7.11(2)(b)

Name of child: ______________________________________________________________

Name of medication: ________________________________________________________

Please ✓ one of the following:     Prescription: _____      Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_______

Topical Non-Prescription (applied to open wound/ broken skin)_______

My child has previously taken this medication________

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_______

Dosage: ___________________________________________________________________

Date(s) medication to be given: _________________________________________________

Times medication to be given: __________________________________________________

Reasons for medication: _______________________________________________________

Possible side effects: _________________________________________________________

Directions for storage: ________________________________________________________

Name and phone number of the prescribing health care practitioner: ______________________

Child’s Health Care Practitioner Signature __________________ Date ______________

I, __________________________________________, (parent or guardian) gives permission (print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature __________________ Date ______________

For topical, non-prescription NOT applied to open wound / broken skin (parent signature only)