

## MEDICATION ADMINSTRATION AND CONSENT FORM

\*\*All medication must not be expired and come in its original, labelled container. Prescription medication must have the prescription label attached\*\*

## \*\*\*DOUBLE SIDED\*\*\*

| Student's Name   |   |   |
|--|---|---|
| Student's Name   | First Name  | Last Name   |
| Medication to be given   |   |   |
| Amount to be given (dosage) _  |   |   |
| Ι,   |   | , give permission for the medication listed above, in the dosage  |
| amount also listed above, to be  | administered to my cl   | hild,   |
| from   | (month/yea  | ar) until it is no longer required or my child (named above) has  |
| withdrawn from the program.  |   |   |
| Type of allergy or health conce  | rn, if applicable   |   |
| Signs and symptoms indicating  | that the medication is  | required to be administered   |
|  |   | ood)  |
| (PREFERRED), it will be stored will not be providing us with the backpack EVERY time he/she at | in our staff backpack, of<br>medication to leave at<br>stends the program. His/ | tion can stay on-site with the program during operational months out of reach of all children but easily accessible to all staff. If you the program, then your child must have the medication in his/her /her backpack will be out of reach of all children but easily vays kept locked up and out of reach of all children. |
| CONSENT:   |   |   |
| I,   |   | hereby give consent to the teachers and staff of A Child First  |
| Preschool Inc. to administer th  | e above listed medicat  | ion to my child,  |
| as per the instructions above. I   | also consent to the mo  | edication storage details listed above.   |
| Parent/Guardian's Signature  |   | Receiving Staff's Signature   |
| Date   |   | Date  |

| Student's Name |            |           |  |
|----------------|------------|-----------|--|
|                | First Name | Last Name |  |

## \*IF MORE THAN ONE DOSE OF MEDICATION IS ADMINISTERED, BE SURE TO RECORD EACH ONE ON A SEPARATE LINE\*

| DATE         | MEDICATION ADMINISTERED *Use official medical name* | DOSAGE | TIME   | STAFF SIGNATURE | PARENT SIGNATURE |
|--------------|---|--------|--------|-----------------|------------------|
| Mar 22, 2024 | Example: Salbutamol                                 | 1 Puff | 1:38pm | *Sample         | *Sample*         |
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## MEDICATION ADMINSTRATION AND CONSENT FORM RENEWAL \*ADMINISTRATION USE ONLY\*

Please Note: This form will only be used for each <u>new</u> school year in lieu of parents/guardians filling out a new medication consent form for the exact same medication that will be brought to the program with the child named below. Staff are required to check that all students who require medication have it with them every day. Directors conduct a monthly checklist that includes reviewing all student medication forms and medications.

| Student's | s Name:  |   |                 |
|-----------|--|---|-----------------|
|           | First Name   | Last Name   |                 |
|           |  |   |                 |
| Date:     | Has any information changed?  Parent must sign off on any changes (Ex: Dosage) | Staff Name & Signature (who reviewed the renewal) | Parent Signatur |

| Date: | Has any information changed?  Parent must sign off on any changes (Ex: Dosage) | Staff Name & Signature (who reviewed the renewal) | Parent Signature |
|-------|--|---|------------------|
|       | T arem must sign off on any changes (Ex. Dosage)                               | (morevewed merened)                               |                  |
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