Medication Consent Form

Child's Name _____ Date _____

Date of Birth _____ Classroom _____

I authorize the nurse to give my child the following medications.

NOTE: All medications must be in the original container. All prescription medications will only be dispensed according to the pharmacy label. All non-prescription medications must have a LeafSpring School label affixed (without obscuring the original label) indicating child's name, name of medication, frequency of administration and amount to be given.

Use separate Medication Consent Forms for each medication unless two are used together for the same condition per doctor.

Medication**	Dose**	Circle time to be given	Reason for Med	# of days to be given*	Exp. Date
		12:00 – 4:00 – PRN***			
		12:00 – 4:00 – PRN***			

* This form shall expire or be renewed after ten work days unless a doctor's note is provided, which is required for long-term medications.
** If medication and/or dose changes for long-term medications, a new doctor's note must be on file.
*** Other medication times are available per physician's order on prescribed medications.

Special instructions for giving medication. Please note any known side effects or adverse reactions to the medication:

_____

Signature of Parent_____ Date_____

Office Use Only

Long-term Medications *ONLY*
Annual Doctor's Note on File ☐ Date on note:_____

MEDICATION ADMINISTRATION RECORD

Record time each medication is given and initial below.

Please make sure that a doctor's note is provided annually for long term medications.

****** Controlled Substances MUST be counted BEFORE giving medication.***

*Controlled Substance Count****											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

*Controlled Substance Count****											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

MEDICATION ADMINISTRATION RECORD

Record time each medication is given and initial below.

Please make sure that a doctor's note is provided annually for long term medications.

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											

Controlled Substance Count***											
Medication	Dose	Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____		Date ____/____/____	
		Time	Initial	Time	Initial	Time	Initial	Time	Initial	Time	Initial
Note any adverse reactions, date & action(s) taken by nurse:											