CLINTON CO-OPERATIVE CHILDCARE CENTRE INC.
MEDICATION CONSENT FORM

Parents fill in bold areas only and if not complete, medication will not be given

Child's Name: _____ **Parent's Name:** _____

Start Date: _____ **Finish Date:** _____

Medication: _____ **Expiry Date:** _____

Diagnosis: _____

Time to be Administered: _____ **Dosage:** _____ **Max Dosage Per Day:** _____

Possible Reactions to Medication: _____

Refrigerated: Yes No

Time last administered at time of consent: _____

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

Location of Medication: _____

Date	**Parent Signature**	Amount Given	Time Given	Staff Name	Staff Signature

Staff check off the following and sign when accepting medication:

Name on Medication	Original Bottle	Dosage Amount on Box/Label	Start and Finish Date	Stored as per Instructions	Returned to parent When finished

Staff Signature: _____

Supervisor Signature: _____

Updated January 2025