

Commonwealth of Massachusetts  
Department of Early Education and Care

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

Name of child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Town: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Please check one of the following: Prescription: \_\_\_\_\_ Oral/Non-Prescription: \_\_\_\_\_

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 \_\_\_\_\_  
(initial)

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Dosage: \_\_\_\_\_

Date(s) medication to be given: \_\_\_\_\_

Time medication to be given: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

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I, \_\_\_\_\_ (parent or guardian) give permission  
(print name)  
to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Cell: \_\_\_\_\_