MASSACHUSETTS CHILD CARE
PARENT CONSENT/ MEDICATION AUTHORIZATION FORM
Complies with 606 CMR 7.11(2)(b)

*Top portion must be filled out by prescribing physician -One form per medication****-OR**

Any written order from the Dr can be substituted as long as it contains all the required information

Name of Child:____DOB____________________

Name of Medication:____

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

Dose:_______________________Strength:__________________Route:____________________

Date(s) medication to be Administered:____

Time(s) Medication to be Administered at School:____

Reason for Medication:____

Possible Side Effects:____

Directions for Storage:____

Please note Emergency Medication cannot be locked Per Massachusetts Child Care regulations

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Name and Phone Number of Prescribing Physician:_____________________________________

List of additional medications that the child is on:____________________________________

Physician's Signature:________________________________Date_________________________

Parent Consent, Parent must sign below:

I, ____(Parent/Guardian) give permission to authorized staff to administer the medication indicated above to my child. I understand the prescriber of the medication will be called if any questions arise related to the administration of this medication. I further authorize the release of any information necessary for the care of my child named above.

Signed____Date___________________________

To be filled out by Parent:
In the event that my child has more than one medication prescribed by more than one physician, I authorize the center to contact the physician listed below to oversee my child's medication administration record.

*Name of Physician:*____

*Phone number:*____

In accordance with HIPAA and applicable state laws, all personal medical information is private and will be protected. Parents and guardians signing this document have a legal right to receive a copy of this authorization.

