COLUMBIA CHILDREN’S CENTER WRITTEN MEDICATION CONSENT FORM

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| --- | --- | --- |
| Child’s First and Last Name: | Date of Birth: | Child’s Known Allergies: |
| Facility Name:Columbia Children’s Center | Facility ID number:00040679DCC | Facility Telephone and Fax:518-828-2465 |

**TO BE COMPLETED BY MEDICAL PROVIDER:**

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| --- | --- | --- |
| Name of Medication: | Amount/Dosage: | Route of Administration: |
| Length of time to be given or discontinue date: | Times to be administered: | Refrigeration Required?YES \_\_\_\_ NO \_\_\_\_\_ |
| Reason to taking medication (unless confidential by law): |
| Possible Side Effects: | What action to take if side effects noted: |
| Special Instructions: |
| (Complete this section for PRN medication only): Identify the symptoms that will necessitate administration of medication: |
| Medical Provider Name: | Medical Provider Telephone: |
| Medical Provider Signature: Date: |

AUTHORIZATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Columbia Children’s Center to administer the medication listed above to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Day Care Staff who received this statement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Care Staff Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_