MEDICATION CONSENT FORM
SEEDLINGS PRESCHOOL

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Facility)
_____, to my child _____, as follows:
(Specify, prescribed medication over the counter products) (Child's Name)

Directions:

1. Child's Name	2. D.O.B.
3. Date to Begin the Medication	4. Date to Stop Medication
5. Times Medication is to be Given	6. Dosage
7. Storage of Medication	
8. Allergy Symptoms	
9. Other Directions/Instructions, If Any	
Parent's Name	
Signature of Parent	Date (DD/MM/YYYY):

TO BE COMPLETED BY THE TEACHER:

Medication Name	Date	Time	Dosage	Teacher's Initials

Parent's Name_____ Parent's Signature_____ Date:_____