Community Care Facilities Licensing

Medical Administration Consent

fraserhealth

CHILD'S NAME	
MEDICATION	PRESCRIPTION # *(if applicable)*
DOSAGE OF MEDICATION	HAS THE CHILD TAKEN MEDICATION BEFORE? Yes ☐ No ☐
TIMES OR SYMPTOMS FOR WHEN MEDICATION IS TO BE GIVEN BY CARE PROVIDER	
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?	

I authorize the administration of the above medication, in the dosage and frequency stated above to my child. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the **correct medication in its original container**. I will submit a new consent form if there are any changes to this medication, the dosage or the frequency of administration.

Signature of Parent/Guardian	Date	Telephone

ADMINSTRATION RECORD *(completed by the caregiver administering the medication)*

Date *(dd/mmm/yyyy)*	**Time Given** *(hr / min)*	**Dosage Administered**	**Administered by** ***(signature)***