# Longwood Medical Area Child Care Center

Commonwealth of Massachusetts
Department of Early Education and Care

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

Name of child:

_____

Name of medication:

_____

Please √ one of the following:

Prescription: ☐ Oral/Non Prescription: ☐

Unanticipated Non-Prescription for mild symptoms ☐

Topical Non-Prescription **(applied to open wound/broken skin)** ☐

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. ☐

Dosage:_____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication to be given: _____

Possible side effects: _____

Directions for storage: _____

395 Longwood Avenue, Boston, MA 02215 • Telephone: 617-632-2755 Fax: 617-632-2724
Email: kquinn@masco.harvard.edu

Name and phone number of prescribing health care practitioner:

_____

**Child's Health Care Practitioner Signature_____ Date_____**

**I, _____, (parent or guardian) give permission to authorize educator(s) to administer medication to my child as indicated above.**

**Parent/Guardian Signature_____**

**Date _____**

For topical, non-prescription **NOT** applied to open wound/broken skin **(parent signature only)**

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