Peake Childhood Center (PCC)

MAT

Written Medication Consent Form

1. Child's first and last name: ____

2. Date of Birth: _________________

3. Child's known allergies:

   ____

   ____

4. Name of medication (s) (including strength)

   ____

   ____

5. Amount/dosage to be given: ____
6. Route of administration/way medication is to be administered: _________________
7. Frequency to be administered: ____
8. What action should the childcare provider take if side effects are noted:

   ☐ Contact parent

   ☐ Contact prescriber at phone number provided below

   ☐ Other (describe below)

   ____

9. Reason the child is taking the medication (unless confidential by law):

   ____

   ____

10. Date consent form completed: _______________________________
11. I, parent/legal guardian authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to ___________________________

    (child's name)

12. Parent or legal guardian's name (please print): _____________________________________
13. Date authorized: ___________________________
14. Parent or Legal guardian's signature: ____

Information Below For Office Use Only

Provider/Facility Name: Peake Childhood Center

Facility telephone number: 757-825-6200

Authorized childcare provider's name (please print): ______________________

Dated received from parent: ______________________________

Authorized childcare provider's signature: _______________________________