

CNGR –Written Medication Consent Form

- One form must be completed for **each** medication.

Child's Last and First Name	Date of Birth	Child's Known allergies
Name of medication (including strength)	Amount/Dosage to be given	Route of Administration
7 A. Frequency to be administered _____		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____		
Possible side effects: _____ _____		
What action should child care provider take if side effects are noted: <input type="checkbox"/> Contact Parent <input type="checkbox"/> Contact Prescriber at phone number _____ <input type="checkbox"/> Other – describe: _____		
Special Instruction: <input type="checkbox"/> See medication box for complete list of special instructions (parent must supply) Additional special instructions: Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of medication as it relates to the child's age, allergies or any pre-existing condition. Also described situations when medication should not be administered. _____		
Reason the child is taking the medication: _____		
Date Prescriber authorized:	Date to be discontinued or length of time in days to be given:	
Prescriber's Name (Print)	Telephone Number:	
Licensed authorized prescriber's signature:		

Do the instructions indicate a specific time to administer the medication? For example, did the Prescriber write 12pm?) <input type="checkbox"/> NO <input type="checkbox"/> YES, Write specific times(s) the CNGR is to administer the medication (i.e.: 12pm):	
I, parent, legal guardian, authorize the CNGR to administer the medication as specified above Caregiver Signature:	
21. Parent/legal guardian Name (please print)	22. Date:

Licensed Authorized Prescriber to complete, as needed

Describe any addition training; procedures or competencies the CNGR staff will need to care for this child.

Licensed Authorized Prescriber's Signature:

Since there may be instances where the pharmacy will to fill a new prescription for changes in a prescription related to dose, time and frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:

By completing this section the CNGR will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

Licensed Authorized Prescriber' s Signature

Staff Name _____ **Date** _____