**BOWEN AFTER SCHOOL CARE PROGRAM, INC.**

280 CYPRESS STREET, NEWTON, MA 02459

617-969-3130

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

Name of child: _____

Name of medication: _____

**Please check 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: _____ **No first time medications will be administered in BASCP***
***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: _____

Reason for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

**Child's Health Care Practitioner Signature: _____ Date: _____**

**I, _____, (parent/guardian) gives permission to authorize educator(s) to administer medication to my child as indicated above.**
**(print name)**

**Parent/Guardian Signature: _____ Date: _____**
For topical, non-prescription NOT applied to open wound/broken skin (parent signature only)

| Office use: | Parent Initials: |
|---|---|
| Date Medication Received: _____ | _____ |
| Date Medication Returned: _____ | _____ |