LIVING ROCK ACADEMY SHORT TERM MEDICATION CONSENT

Name of child: _____

1. Name of medication: _____

Prescription: _____ Non-Prescription: _____

Dosage:_____

Times medication to be given: _____

Reason for medication: _____

Possible side effects: _____

Directions for storage: _____

I, _____, (parent or guardian) give permission to authorized staff member(s) to administer medication to my child as indicated above.

_____ _____

Parent/Guardian Name & Signature Emergency Contact Number