SCHOLA BOHEMIA SERVICES
MEDICATION ADMINISTRATION
CONSENT FORM

Photo

NOTE: NO Medication will be given until this form is completed and returned to Schola Bohemia Services.

Child's Name:	DOB (DD/MM/YYYY):
Physician's Name:	Phone #:
Pharmacy Name:	Phone #:
Medication:	Prescription #:

Dosage of Medication	Has child taken this medication before?	○ YES	○ NO
	If NO, has child received medication for 24 hrs. prior returning to the care program?	○ YES	○ NO

Times to be given by care provider:

Any possible side effects that you have been made aware of by the physician or Pharmacy?

I hereby authorize Schola Bohemia Services to administer the above medication, in the dosage and frequency stated above to my child. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the correct medication in its original container. I further agree to submit a new consent form if there are any changes to this medication, the dosage, route or frequency of administration.

I also understand, that if non-prescription medications are to be given, a note from the doctor must be provided and it will be only accepted and administrated by Schola Bohemia Services for Health-threatening circumstances.

_____ _____ _____

Signature of Parent/Guardian Date Phone number

Administration Record (completed by the caregiver administering the medication):

DATE (DD/MM/YYYY)	*TIME GIVEN (HR/MIN)*	*DOSAGE ADMINISTERED:*	*ADMINISTERED BY: (SIGNATURE)*