



Verbal Medication Consent Form and Log of Administration

- Use this form if:
 - A parent or guardian arrives at the program requesting medication be given but does not have written instructions from the authorized prescriber.
 - A child develops symptoms while in your care that require the administration of an over-the-counter medication
- The medication authorized on this form is valid for one day only. This consent form does not authorize the administration of the medication listed below on multiple days.

1. Child's first and last name:	2. Name of medication (including strength):	3. Amount/dosage to be given:
4. Route of administration:		5. Frequency to be administered for today only:
6A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (must be obtained from medication package or insert)		
AND/OR		
6B: Additional side effects: _____		
7. What action should the program take if side effects are noted:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided <input type="checkbox"/> Other (describe): _____		
8A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (must be obtained from medication package or insert)		
AND/OR		
8B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions.)		
Also describe situations when medication should not be administered.) _____		
9. Provider/Facility name:	10. Facility ID number	11. Facility telephone number:
12. I, _____ received verbal permission from _____		
<div style="display: flex; justify-content: space-between;"> (name of day care provider) (child's parent or legal guardian) </div>		
to administer the medication listed above on ____ / ____ / ____.		
<div style="display: flex; justify-content: center;"> (date authorized to </div>		
match the instructions for use on the medication container. If the instructions do not match, I received verbal or written instructions from the health care provider or licensed authorized prescriber.		

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

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13. COMPLETE THIS SECTION FOR VERBAL MEDICATION CONSENTS REQUIRING HEALTH CARE PROVIDER INSTRUCTIONS

In addition to the above parent/guardian consent I, _____ received verbal instructions from _____
(name of day care provider)
(check the credentials of person)

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Registered Nurse on behalf of the child's physician, PA or NP

to administer the medication listed above on _____. A request was made to have the
(date authorized to give)
health care provider send the medication instructions in writing.

14. Licensed prescriber's name (physician, PA or NP):

15. Licensed prescriber's telephone number:

16. I have verified that sections #1 - #15 are complete. My signature indicates that all information necessary to safely administer this medication has been given to the day care program.

17. Authorized child care provider's name (please print):

18. Date received from parent:

19. Authorized child care provider's signature:

X

Document the administration of the medication in the log below

Date Given	Medication	Dose	Time Given	Signature of Day Care Provider

PARENT ACKNOWLEDGEMENT OF VERBAL CONSENT

I, parent/legal guardian, gave verbal permission to the day care program to administer the above indicated medication on

(date)

Parent or Legal Guardian's Signature:

X