Allergy Medication Administration Consent Form

Child's Full Name

Date of Birth

Parent/Guardian Information

Parent/Guardian Name

Contact Number

Email Address

Allergy Details

Describe Allergy

Allergen(s) (specify food, medication, etc.)

Typical Reaction/Symptoms

Medication Information

Medication Name

Dosage

Route of Administration (e.g., oral, injectable)

Frequency / Timing

Special Instructions

Authorization

I authorize the designated personnel to administer the above medication to my child as specified. I agree to notify the organization of any changes in the medication or administration.

Parent/Guardian Signature

Date

Staff Signature

Date