

PARENTAL CONSENT FOR WEIGHT-BASED DOSAGE ADMINISTRATION

Date: [Insert Date]

Child's Information:

Full Name: [Insert Child's Full Name]

Date of Birth: [Insert Date of Birth]

Current Weight: [Insert Weight] [kg/lbs]

Date Weight was Recorded: [Insert Date]

Parent/Guardian Information:

Full Name: [Insert Parent/Guardian Name]

Phone Number: [Insert Phone Number]

Authorization:

I, [Insert Parent/Guardian Name], am the legal parent/guardian of the child named above. I hereby authorize [Insert Name of School/Facility/Provider] to administer the following medication(s) based on my child's current weight as calculated by a healthcare professional or according to the manufacturer's instructions:

Medication Details:

Medication Name: [Insert Medication Name]

Dosage Formula: [e.g., X mg per kg]

Purpose of Medication: [Insert Reason for Medication]

Frequency/Time of Administration: [Insert Schedule]

Emergency Contact:

In case of an adverse reaction, please contact [Insert Emergency Contact Name] at [Insert Emergency Phone Number] immediately.

Consent Statement:

I understand that the dosage is determined by weight to ensure safety and efficacy. I agree to notify the administration immediately if there is a significant change in my child's weight or medical condition. I release [Insert Name of Facility] from liability related to the administration of this medication as directed.

Parent/Guardian Signature

Date Signed