MEDICATION AUTHORIZATION FORM

To be completed by the child's parent or guardian for medications taken for 10 business days or less.

Child's Name: _________________________________ Medication: ____

Dosage/time(s) to be administered: ____

Route: _______________________________________ Purpose of Medication: ____________________________________

Special Instructions: ____

Possible Side Effects: ____

This authorization is effective from: ___________________________________ until _______________________________

I hereby give permission for the above listed medication to be administered to my child while in care.

Parent's or Guardian's Signature: ____ **Date:** _________________________

*The medication is to be brought in the original container which clearly identifies the child's name, name of the medication, time, dosage and route. This form must be completed in order for the medication to be given.

To be completed by the child's parent <u>AND</u> physician for long-term medications taken longer than 10 business days.

Child's Name: _________________________________ Medication: ____

Dosage/time(s) to be administered: ____

Route: _______________________________________ Purpose of Medication: ____________________________________

Special Instructions: ____

Possible Side Effects: ____

This authorization is effective from: ___________________________________ until _______________________________

Physician's Signature: ____________________________________ **Phone:** _____________________**Date:** ___________

I hereby give permission for the above listed medication to be administered to my child while in care.

Parent's or Guardian's Signature: ____ **Date:** _________________________

*The medication is to be brought in the original container which clearly identifies the child's name, name of the medication, time, dosage and route. This form must be completed in order for the medication to be given.