Medication Authorization Form

Complete this form if your child requires medication to be administered while in our care. Prescription medication should be in its original labeled container.

Field	Information
Child's Name	_____
Medication Name	_____
Prescription or Over-the-Counter	■ Prescription ■ Over-the-Counter
Reason for Medication	_____
Dosage	_____
Route (Oral, Topical, etc.)	_____
Time(s) to Administer	_____
Start Date	_____
End Date	_____
Special Instructions	_____
Physician Name (if applicable)	_____

Parent/Guardian Signature: _____

Date: _____

Staff Initials (when medication is accepted): _____