Medication Authorization Form

(Must be completed for all Prescription and Non-Prescription Medication)

Name of child:_____

Child's condition for administering medication:
_____cold _____sore throat _____rash _____ear infection _____teething
_____injury _____other_____

Name of medication/procedure_____
_____Prescription _____Non-prescription

Amount to be administered_____
Time(s) to be administered_____

Dates to be administered From_____ To_____

Refrigeration necessary _____yes _____no

Special instructions_____
_____

Possible adverse reactions_____
_____

I authorize the administration of this medication to my child.

_____ _____
Parent Signature Date

THIS FORM MUST BE ACCOMPANIED BY A DOCTOR'S NOTE

Date(s) Administered	Time(s) Administered	Dose	Reactions/ Observations	Staff Member's Initials