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

<table>
<thead>
<tr>
<th>Date(s) Administered</th>
<th>Time(s) Administered</th>
<th>Dose</th>
<th>Reactions/ Observations</th>
<th>Staff Member’s Initials</th>
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