MEDICATION AUTHORIZATION FORM

Begin Date:_____

Expiration Date:_____

Child's Full Name _____

Name of Medication _____

Prescription Number _____

Time Medication is to be given: _____

Amount of Medication to be given: _____

Date(s) to be given: _____(max. of two weeks)

_____ _____

Signature (Parent/Guardian) Date

For Staff Use

Date	Time Given	Amount	Any Adverse Reactions	Administered By
1.				
2.				
3.				
4.				

If noticeable adverse reaction to medication what action was taken? Describe.

_____

_____