

## AUTHORIZATION FOR MEDICATION

Child's Full Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescription Number: \_\_\_\_\_

Time Medication is to be given: \_\_\_\_\_  
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: \_\_\_\_\_

Dates to be given: \_\_\_\_\_  
(Not to exceed two weeks without a physician's statement)

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
DATE

**FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)**

	<u>DATE</u>	<u>TIME GIVEN</u>	<u>AMOUNT</u>	<u>ANY ADVERSE REACTIONS</u>	<u>ADMINISTERED BY</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

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

**Attention to Person Requesting Medication Be Dispensed:**  
**Form must be completed in it's entirety before the center can dispense any**  
**medication**