



## Authorization for Medication

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

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

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

(\* We **MUST** have a doctor's note on file before administering medication.)

Time Medication is to be given \_\_\_\_\_

(\* Please write EXACT times to be given. Please DO NOT write "as needed".)

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

Dates to be given \_\_\_\_\_ thru \_\_\_\_\_

\* Dates to be given should not exceed two weeks. A new form must be filled out every two weeks if medicine is to continue.

\_\_\_\_\_  
Signature (Parent/Guardian)

\_\_\_\_\_  
Date

\* PLEASE FILL THIS FORM OUT COMPLETELY & RETURN TO THE FRONT DESK. THANK YOU!

### For Center Use:

Date	Time Given	Amount Given	Any Adverse Reactions	Administered by
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____

If notice adverse reaction to medication what action was taken? Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_