**MEDICATION AUTHORIZATION FORM**



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…)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE | TIME GIVEN | AMOUNT | ADMINISTERED BY | ANY ADVERSE REACTIONS |
| **1.** |  |  |  |  |
| **2.** |  |  |  |  |
| **3.** |  |  |  |  |
| **4.** |  |  |  |  |
| **.5** |  |  |  |  |
| **.6** |  |  |  |  |

(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 .***