AUTHORIZATION FOR MEDICATION

Child's Full Name: _____ Room # _____

Name of Medication: _____

Prescription Number:_____ Over the Counter:_____

Time Medication is to be given: (circle one or both): 12noon 4:00pm

(**Medication will not be given on an "As Needed" basis, specifics must be provided)**

Amount (dosage) of medication to be given each time: ml____ tsp____ puffs____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

_____ _____

Parent's Signature Phone #

Date: _____

For Center Use (Reminder: document the reason why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc…)

	Date	Time Given	Amount	Any Adverse Reactions	Administered By
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 its entirety before the center can dispense any medication