



Prepare | Explore | Empower

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION
IN SCHOOL OR CHILD CARE

Student's Name: _____ DOB: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of Medication: _____

Side effects that need to be reported: _____

Start Date: _____ End Date: _____

Signature of Health Care Provider with Prescriptive
Authority License Number

License Number

Printed Name of Health Care Provider

Phone Number

Date

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.

The Journey Starts Here...