

Medication Authorization Form

Child's Name: _____

Medication Name*/Strength: _____

Dosage Amount/Frequency: _____

How to be Given: Oral Topical Other: _____

Time to be Given: _____ Date(s) to be Given: _____

Side Effects/ Anticipated Reactions: _____

Special Instructions (If Applicable): _____

 Parent's Signature

 Date

If all information is not filled in completely, medication will not be given.

Administration Documentation

Date Given	Time Given	Dosage Given	Signature of Person Administering Medication

Signature of Staff Completing this form: _____

**medication should be in its original container*

