



Medication
Authorization Form

No medication shall be given by facility staff without the signed permission of a parent or guardian. Prescription medicines ONLY will be given as prescribed on the label. We will give over the counter medications with a doctor's note documenting the name of the child, medication to be given, dose and frequency. If a medicine is: prescribed 4 X/day, we will give it 2 X; prescribed 3 X/day, we will give it 1 X; prescribed once daily, you are responsible. Medications are given at 11 a.m. and/or 3 p.m. daily.

CHILD'S NAME: _____

MEDICATION: _____ PRESCRIPTION #: _____

AMOUNT TO BE GIVEN: _____

TIME(S) TO BE GIVEN: _____

DATE(S) TO BE GIVEN: _____ (NOT TO EXCEED 2 WEEKS)

| <u>DATE</u> | <u>TIME GIVEN</u> | <u>AMOUNT GIVEN</u> | <u>ADVERSE REACTION</u> | <u>INITIALS</u> |
|-------------|-------------------|---------------------|-------------------------|-----------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

My signature indicates authorization for the facility staff to administer medication to my child according to the directions provided above.

Parent/Guardian Signature

Date