Building tomorrow's leaders today

MEDICATION AUTHORIZATION FORM

Each time a dose of medication is administered, an entry will be made at the bottom of this form. If a dose is omitted, an entry will also be made indicating the reason. Although every effort will be made to administer medication as requested, due to unforeseen circumstances, this may not always be possible.

Name of Child: _____ **Grade:** _____

I hereby authorize the administration of the following medication to the above-named child:

_____
(Name of Medication)

prescribed by: _____
(Name of Physician)

Storage: ❑ Refrigeration is required. ❑ Refrigeration is not required.

Time to be given: ❑ 12:00 – 1:00 pm ❑ 3:00 – 4:00 pm
(Except in emergencies, medication will be given at these times.)

Dosage:

Stop the medication, if the following is observed: _____

_____

Starting Date: _____ Ending Date: _____

AND/OR, where drugs are to be administered on an *'as needed'* basis:

❑ The "*as needed*" drug or medication needs to be administered when the following symptoms are observed:

_____

Amount/Dosage: Frequency?: (e.g. every 6 hours)

Parent/Guardian Authorization Statement:

_____ _____
Parent's Signature Date

Date	Time Given	Staff Initials	Comments