



Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Start Date:	Stop Date:
Times to be given: (cannot be 'as needed')	Amount to be given:
Possible Side Effects:	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other:
<input type="checkbox"/> Above information is consistent with label.	Requires Refrigeration: <input type="checkbox"/> Yes <input type="checkbox"/> No
Special Instructions:	

* All items must be in their original container with prescription on container.

Parent/Guardian Signature Daytime phone Date

Physician Signature Physician phone Date

Physicians signature is only required if instructions differ from the prescription. A prescription is a doctor's authorization for that medication.

Medications returned to parents or discarded
(must be completed after stop date and before filing form in child's file)

