§1917.A ,H

Medication Authorization Form

Medicine Must Be In Its Original Container

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): ____________________________

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__________________________ ____________

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

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Signature of Staff Completing Form