

## 3-DAY CRITICAL MEDICATION AUTHORIZATION FORM

(These medications are to be used only in case of disaster requiring the child to remain in care past usual hours)

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Date to be replaced/rotated*:	Expiration date of medication:
□ Scheduled times to be given (please list times below):	☐ To be given as needed for the following symptoms (list symptoms below):
Dose (Amount to be given):	
Possible Side Effects:	Route:  Oral Dopical Other
Above information consistent with label	Requires Refrigeration: ☐ Yes ☐ No
Special Instructions:	
* Maximum 6 months – sooner as needed.	
Parent/Guardian: Please inform child care prog	gram if child's health status/medication changes.
Health Care Provider Name (please print)	() Phone Number
Health Care Provider Signature	Date
Parent/Guardian Name** (please print)	()Phone Number
Parent/Guardian Signature	Date