

## Medication Authorization Form

<b>Child's Name:</b>	<b>Date of Birth/Age:</b>
<b>Name of Medication:</b>	<b>Reason for Medication:</b>
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <b>Expiration Date:</b>              ____ / ____ / ____           </div>	
<b>Medication Start Date:</b> ____ / ____ / ____	<b>Medication Stop Date:</b> ____ / ____ / ____
<b>Times to be given:</b>  (CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication)	<b>Amount to be given:</b>
<b>Possible side effects:</b>	<b>Route:</b>  <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
	<b>Requires Refrigeration:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Above information consistent with label?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Special Instructions:</b>	

\_\_\_\_\_  
**Health Care Provider Name** (please print)

(\_\_\_\_) \_\_\_\_\_  
**Phone Number**

\_\_\_\_\_  
**Health Care Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Name** (please print)

(\_\_\_\_) \_\_\_\_\_  
**Phone Number**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

# Medication Record

(Must be filled out by the person who gives the medication)

<b>Child's Name:</b>
<b>Name of Medication:</b>

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

**Initials and signatures of persons giving medication:**

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