



Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Start Date:	Stop Date:
Times to be given: <small>(*Can NOT be given "as needed")</small>	Amount to be given:
Possible Side Effects:	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> yes <input type="checkbox"/> no
Special Instructions:	

Parent/Guardian Signature

Date

Daytime Phone Number

Physician Signature

Date

Physician Phone Number

Medication Record

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

Child's Name:

Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:
