AUTHORIZATION FOR MEDICATION

Child's Name:_____

Name of Medication:_____

Prescription Number:_____ or Over –the-Counter:_____

(IF OVER THE COUNTER, PLEASE ATTACH A DOCTORS NOTE)

Time Medication is to be given: 10:45-11:00 a.m. 2:45-3:15 p.m Other:_____

(Medication CAN NOT be given on an 'AS NEEDED" basis, specifics must be provided)

Amount of Medication to be given:_____

Route medication is to be given :_____

Dates to be given:_____

(A NEW FORM must be filled out EVERY TWO WEEKS)

_____ _____

Parent's Signature Date

Morning Medication Time (10:45-11:15 a.m.)

Date	Time Given	Amount Given	Any Adverse Reaction	Administered By

Afternoon Medication Time (2:45-3:15 p.m.)

Date	Time Given	Amount Given	Any Adverse Reaction	Administered By

If noticeable adverse reaction to medication, what action was taken? Describe: _____

_____