

Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication: <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Expiration Date: ____ / ____ / ____ </div>	Reason for Medication:
Medication Start Date: ____ / ____ / ____	Medication Stop Date: ____ / ____ / ____
Times to be given: <small>(CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication)</small>	Amount to be given:
Possible side effects:	Route: <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:	

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)

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

