MEDICATION AUTHORIZATION FORM

Note: Medication will not be administered to any child if information is not filled in completely.

Child's name:		
Medication name and strength:		
Dosage:	Route: oral topical (circle one)	Medication expiration date:
Date(s) medication to be given:		
Time(s) medication to be given: _____ 10:00 a.m. _____ 2:00 p.m. _____ after school		
Circumstances for "as needed" or other applicable instructions:		
Parent's Signature:		Date:

STAFF RECEIVING MEDICATION CHECKLIST

___ in original container: prescription with complete pharmacy label/non-prescription with original packaging or printed document from website (with name/strength/clear directions for use)

___ labeled with child's name ___ not expired ___ form completed ___ signature/date

___ written authorization from health care provider, if "consult physician" on non-prescription label

_____ initials of staff receiving medication

STAFF ADMINISTERING MEDICATION

Date Administered	Time Administered	Dosage Administered	Staff Signature (full signature)	Parent Contact, if needed (name/time)	Staff Initials

OFFICE USE ONLY
"as needed" or "emergency" expiration date: _____
(6 months)