

MEDICATION AUTHORIZATION FORM: FOR PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for ALL medication authorizations
- **Section A AND B** must be completed for any long-term medication authorizations (those lasting longer than 10 working days)

SECTION A: To be completed by parent/guardian:

Medication authorization for: _____

(Child's name)

_____ has my permission to administer the following medication:

(Name of Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____

Parent's or Guardian's Signature: _____ **Date:** _____

Section B: To be completed by child's physician OR provide a doctor's order:

Medication authorization for: _____

(Child's name)

_____ has my permission to administer the following medication:

(Name of Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____

Physician's Signature: _____ **Date:** _____

****All prescription medications must be labeled from a pharmacy with child's name, DOB, medication name, dosage, time given and expiration date.**