Medication Authorization Form

INSTRUCTIONS:

Must be completed by the parent/guardian for ALL medication authorizations.

Medication authorization for: _____
(Child's name)

_____ has my permission to administer the following medication:

(Name of Child Care Provider)

Medication Name _____ Route of Administration _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

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

MEDICATION LOG

Medication:_____

Date	Time	Amount (given)	Route of Administration	Staff Signature	Adverse Reactions	Any Medication Errors