MEDICATION AUTHORIZATION FORM

Child's Name: _____ **Date of Birth:** _____

Medication: _____ **Start Date:** _____ **End Date:**_____
Reason for medication: _____
Possible side effects:_____
Times to be given *(cannot be given "as needed")*: _____
_____
Amount to be given:_____
☐ **Oral** ☐ **Topical** ☐ **Other:**_____
Requires refrigeration: ☐ **Yes** ☐ **No**
Information consistent with label? ☐ **Yes** ☐ **No**
Special Instructions: _____
_____

_____ _____
Parent/Guardian's Signature Date

_____ _____
Health Care Practitioner's Signature Date

Application Record:

Date	Time	Dose	Initials	Reason NOT given	Side Effects Observed

Signatures & Initials of Persons Administering Medication:
_____ ( ) _____ ( )
_____ ( ) _____ ( )