



MEDICATION AUTHORIZATION



This authorization must be completed any time a child needs prescription medications, non-prescription medication, inhalers, or epi pens.

Child's Name _____

Name of Medication _____

Purpose of Medication _____

Possible Side Effects _____

Please give the above medication accordingly: (ALL PRESCRIPTION MEDICATIONS MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE ONLY. OVER-THE-COUNTER MEDICATIONS MUST ALSO BE IN THEIR ORIGINAL CONTAINERS, PROPERLY LABELED WITH THE CHILD'S NAME IN PERMANENT INK)

Dosage _____

Times _____

Number of Days _____ Or Number of Doses _____

_____ Date

_____ Signature Parent/Guardian

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