MEDICATION AUTHORIZATION

This authorization must be completed any time a child needs prescription medication, non-prescription medication, inhaler, Epi-Pen, nebulizer or any type of health care procedure, whether the authorization is for a short-term or long-term basis.

Child's Name _____

Name of Medication or Procedure: _____

Condition or Indication for administration: _____

Instructions for administration: _____

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 | Name of Parent/Guardian | Signature Parent/Guardian

If the child has a chronic health condition that requires the administration of prescription or non-prescription medication, (i.e. the use of a blood glucose monitor, nebulizer, Epi-Pen, etc..), or requires health care procedures on a long-term basis, the parent must also provide a written statement from a health care professional indicating the following: child's name, name of medication or procedure, the condition or indications for the administration of the medication or procedure, the instructions for the administration of the medication or procedure, and the name and telephone number of the health care provider. The written statement from the health care provider must be attached to this Medication Authorization Form.