

## Authorization for Administration of Medication

**Box 1-** The following section must always be completed by the parent/guardian.

<b><u>Check all that apply:</u></b>	
<input type="checkbox"/> Prescription medication <input type="checkbox"/> Non Prescription medication <input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Topical product or lotion <input type="checkbox"/> Food supplement <input type="checkbox"/> Modified diet
<b><u>Complete all of the following information:</u></b>	
Name of child: _____ Date of birth: _____ Weight: _____	
Name of medication: _____ Exact dosage: _____	
To be administered at the following time: _____	
Parent/Guardian signature: _____ Date: _____	

**Box 2-** The following section must be completed by a *licensed physician, a licensed dentist or an advance practice nurse* when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group eliminated) or food supplement; or
5. The medication contains aspirin.

_____	_____
(name of child)	(name of medication, vitamin, diet)
_____ as follows: _____	
(include dosage and instructions)	
Possible side effects to watch for are: _____	
Expiration date: _____	
_____	_____
Signature of physician, dentist or advance practice nurse	Date of signature
	Phone number

**Box 3-** The section below must be completed by the center staff and each administration of medications must be documented.

**All** dosages must be recorded on page 2 of this form.

Date and Time of Dosage	Name of Medication	Dosage Amount	Signature of Staff Member

