Authorization for Administration of Medication

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

Check all that apply:

- ☐ Prescription medication
- ☐ Non Prescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

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.

_____ is under my care and should receive _____ as
(name of child) (name of medication, vitamin, diet)

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

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