MEDICATION AUTHORIZATION FORM

CHILD'S NAME _____

I,_____, authorize _____ to

administer medication to my child under the following instructions.

Name of Medication: _____

Date to Start: _____

Date to End: _____

Amount of Dose: _____

Time to be given: _____

Special Instructions:
_____
_____
_____

Possible Side Effects:
_____
_____
_____

Instructions for Storage:
_____
_____
_____

Parent's Signature Date

_____ _____