Medication Authorization Form

For prescription and non-prescription medications

Section A must be completed by the parent/guardian for **ALL** medication authorizations. **Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

SECTION A: To be completed by parent/guardian

Medication authorization for: _____. _____
(Child's Name) *(Name of Child Care Provider)*

has my permission to administer the following medication:

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start Date) *(End Date)*

Parent's or Guardian's Signature: _____ **Date:** _____

SECTION B: To be completed by child's physician

I, _____ certify that it is medically necessary for the
(Name of Physician)

medication(s) listed below to be administered to _____ for a duration
(Child's Name)

that exceeds 10 work days.

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start Date) *(End Date)*

Physician's Signature: _____ **Date:** _____

Physician's Phone: _____