Authorization To Administer Medication

Site Use Only:
Amount Received: _____
Received Date: _____
Amount Returned: _____
Returned Date: _____
Notes: _____
_____

I hereby authorize the staff at _____
Program Name

to administer _____
Name of Medication

to _____. Child's Birth Date: _____
Child Name

Type of medication: _____

Specific instructions:_____

(include times) _____

_____

Dosage: _____

Length of authorization: from _____ to: _____
Date – Month/Day/Year Date – Month/Day/Year

_____ _____
Parent or Guardian signature *Date signed*

**** Each instance of administering medication must be noted below and documented in the site medical log.***

DATE AND TIME	NAME OF PERSON ADMINISTERING MEDICATION	CONFIRM LOGGED IN MEDICAL LOG

When the child is no longer required to take this medication, please place this form in his/her file.