Medication Authorization Form

Child's Name:	**Date of Birth/Age:**
Name of Medication:	**Reason for Medication:**
Start Date:	**Stop Date:**
Times to be given: ("Can NOT be given "as needed")	**Amount to be given:**
Possible Side Effects:	☐ **Oral** ☐ **Topical** ☐ **Other**
☐ **Above information consistent with label?**	**Requires Refrigeration:** ☐ **yes** ☐ **no**
Special Instructions:	

Parent/Guardian Signature _____ **Date** _____

Daytime Phone Number _____

Physician Signature _____ **Date** _____

Physician Phone Number _____

Medication Record

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

____ _____ ____ _____

____ _____ ____ _____