Medication Authorization Form

Child's Name and Grade:	**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:	

- **I request and authorize that the above-named student be administered the above- identified oral medication in accordance with the instructions indicated above as there exists a valid health reason, which makes administration of the medication advisable during school hours.**

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Daytime Phone Number(s) **Email**

_____ _____

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:

_____ _____ _____ _____

_____ _____ _____ _____