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

❑ *Medications returned to parents or discarded*
(must be completed after stop date and before filing form in child's file)