Child Medication Authorization Form

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The policy is medication will only be administered if it has been prescribed by a qualified medical practitioner, is in its original container and I have a signed permission form with directions.   |  |  |  |  | | --- | --- | --- | --- | | I, | [Parent’s name] | Authorize, | [Care provider’s name] | | To administer | [Medication] | To my child | [Child’s name] | | With the following instructions: | | | | | Dosage: |  | | | | Time(s): |  | | | |

# Special instructions for my child:

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# Possible Side Effects:

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# Emergency contact:

|  |  |
| --- | --- |
| Name: |  |
| Phone: |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent/Guardian signature |  | Date |

Time and date administered:

|  |  |  |
| --- | --- | --- |
| Date | Time | Provide Initials |
|  |  |  |
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