

Medication Authorization Form

Child's Name:	Date of Birth/Age:	
Name of Medication:	Reason for Medication:	
Start Date:	Stop Date:	
Times to be given:	Amount to be given:	
(*Can NOT be given "as needed")		
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)

ate	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed



Child's Name: