



Medication Authorization Form

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| 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: | <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other |
| <input type="checkbox"/> Above information consistent with label? | Requires Refrigeration: <input type="checkbox"/> yes <input type="checkbox"/> no |
| Special Instructions: | |

Parent/Guardian Signature

Date

Daytime Phone Number

Physician Signature

Date

Physician Phone Number

