



## Medication Authorization Form

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




Initials and signatures of persons giving medication:

\_\_\_\_\_  
\_\_\_\_\_