

Medication Authorization Form

Name:

Date of Birth:

Name of Medication:

Reason for Medication (If for an allergy, please list symptoms as well):

Authorization is effective from: (start date) \_\_\_\_\_to\_\_\_\_\_\_(end date)

Instructions for administration of medication (day/time to give medication, dosage, etc.):

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

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| Staff Name | Date | Name of Medication | Dosage | Time |
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