

MEDICATION AUTHORIZATION FORM

Prescription and non-prescription drugs, including vitamins and aspirin, will be given to a child ONLY with the parent or guardian's COMPLETED written consent.

Child's Name _____ Date of Birth _____

Child's Known Allergies: _____

MCC has my permission to administer the following medication:

Medication Name and Prescription Number: _____

Dosage: _____

Time(s) to be Administered: _____

Special Instructions: _____

Adverse Reaction, if any: _____

Non-prescription Drugs: This form will expire ten (10) business days from the effective date. If medication is still required, a new form will have to be completed. This medication must be taken home daily and brought back the next day if so required.

Date of Authorization: _____

Prescription or Long Term Over-the-counter Drugs: This form will expire one year from the effective date. If medication is still required, a new form will have to be completed. A physician's Authorization Form is also required for Long Term medications. This medication can be kept on site.

Date of Authorization: _____

Signature of Parent and/or Guardian _____

| Date/Time | Medication/Dosage | Any adverse reactions? | Any medication error? | STAFF |
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