## Medication Authorization Form

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Date of Birth/Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Medication:</td>
<td>Reason for Medication:</td>
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<tr>
<td><strong>Expiration Date:</strong></td>
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<tr>
<td>____ / ____ / ____</td>
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<tr>
<td><strong>Medication Start Date:</strong></td>
<td><strong>Medication Stop Date:</strong></td>
</tr>
<tr>
<td>____ / ____ / ____</td>
<td>____ / ____ / ____</td>
</tr>
<tr>
<td><strong>Times to be given:</strong></td>
<td><strong>Amount to be given:</strong></td>
</tr>
<tr>
<td><em>(CANNOT be given “as needed;” must specify time of day and/or symptom for which to give medication)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Possible side effects:</strong></td>
<td><strong>Route:</strong></td>
</tr>
<tr>
<td><strong>☐ Above information consistent with label?</strong></td>
<td><strong>☐ Oral ☐ Topical ☐ Other</strong></td>
</tr>
<tr>
<td><strong>Requires Refrigeration:</strong></td>
<td><strong>☐ Yes ☐ No</strong></td>
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<tr>
<td><strong>Special Instructions:</strong></td>
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<tr>
<td><strong>_________________________________</strong></td>
<td><strong>_____________________</strong></td>
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<tr>
<td><strong>Health Care Provider Name</strong> (please print)</td>
<td><strong>(<strong><strong>)</strong></strong>____________</strong></td>
</tr>
<tr>
<td><strong>_________________________________</strong></td>
<td><strong>Phone Number</strong></td>
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<tr>
<td><strong>Health Care Provider Signature</strong></td>
<td><strong>_____________________</strong></td>
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<td><strong>_________________________________</strong></td>
<td><strong>Date</strong></td>
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<tr>
<td><strong>Parent/Guardian Name</strong>** (please print)</td>
<td><strong>(<strong><strong>)</strong></strong>____________</strong></td>
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<tr>
<td><strong>_________________________________</strong></td>
<td><strong>Phone Number</strong></td>
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<tr>
<td><strong>Parent/Guardian Signature</strong></td>
<td><strong>_____________________</strong></td>
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<tr>
<td><strong>_________________________________</strong></td>
<td><strong>Date</strong></td>
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</tbody>
</table>
Medication Record
(Must be filled out by the person who gives the medication)

Child’s Name:

Name of Medication:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Initials</th>
<th>Reason NOT Given</th>
<th>Side Effects Observed</th>
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</tbody>
</table>

Initials and signatures of persons giving medication:

____  ______________________  _____  ______________________
____  ______________________  _____  ______________________
____  ______________________  _____  ______________________