

Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> Expiration Date: ____ / ____ / ____ </div>	
Medication Start Date: ____ / ____ / ____	Medication Stop Date: ____ / ____ / ____
Times to be given: <small>(CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication)</small>	Amount to be given:
Possible side effects:	Route: <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:	

Health Care Provider Name (please print)

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Phone Number

Health Care Provider Signature

Date

Parent/Guardian Name** (please print)

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Phone Number

Parent/Guardian Signature

Date



