Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication: Expiration Date: ____/____/____	Reason for Medication:
Medication Start Date: ____/____/____	Medication Stop Date: ____/____/____
Times to be given: (CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication)	Amount to be given:
Possible side effects:	Route: ☐ Oral ☐ Topical ☐ Other
☐ Above information consistent with label?	Requires Refrigeration: ☐ Yes ☐ No
Special Instructions:	

____
Health Care Provider Name (please print)

____
Phone Number

____
Health Care Provider Signature

____
Date

____
Parent/Guardian Name** (please print)

____
Phone Number

____
Parent/Guardian Signature

____
Date