Medical Authorization Form

PRESCRIPTION ONLY
Information about the child and the medication
(Completed by parent/guardian)

Child's Name	Age	DOB	Child's Classroom Assignment
Medication Permission VALID	**From**________/______/_______	**To**_________/_______/ _______	
Medicine RX #	Expiration Date	Time ☐ _________ ☐ _________	Dosage	Route ☐ Ear (R/L) ☐ Nose ☐ Mouth ☐ Eye (R/L) ☐ Topical
Medication Directions (per prescription)				
Possible Reactions				
Prescribing Physician				
Pharmacy	Pharmacy Phone			

I give authorization to dispense medication listed above in accordance with the written directions on the prescription label and printed manufacturer's label. This authorization form must be maintained and is only valid for the duration of the prescription.

Parent/Guardian Signature	**Today's Date**

Medication Log ***(Completed by child care provider)***

WEEK 1	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Medicine										
Date										
Actual Time Given	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Dosage/Amt										
Route										
Adverse Reaction										
Staff Signature	AM- PM-		AM- PM-		AM- PM-		AM- PM-		AM- PM-	
WEEK 2	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
Medicine										
Date										
Actual Time Given	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Dosage/Amt										
Route										
Adverse Reaction										
Staff Signature	AM- PM-		AM- PM-		AM- PM-		AM- PM-		AM- PM-	

Describe error or mishap in a Medical Error Form

Date/Time	Error/Mishap	Parent/Guardian Notified?	Staff Signature
		___Yes ___No	
		___Yes ___No	

RETURNED Medication	Date	Parent/Guardian Signature	Child Care Staff Signature
DISPOSED of Medication	Date	Child Care Staff Signature	Witness Signature