# *Medication Authorization Form & Log*

**Child's Name:** _____ **D.O.B**. _____/_____/_____

**Any known medication allergies**: _____

**MEDICATION NAME** **DOSAGE** **TIMES/DAY** **ROUTE** **MEDICATION EXP. DATE** **REASON**

***All Prescription medications will need doctor approval and need a specific start and end date.**

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For the following period beginning _____/_____/_____and ending _____/_____/_____

**Special Instructions:**_____

**Parent/Guardian Signature:** _____**Date**:_____/_____/_____

**Doctor's Signature**: _____ **Date:** _____/_____/_____

**Doctor's Phone #:** (_____) _____-_____

**Administrator Signature:** _____ Date:_____/_____/_____

**Parents MUST supply their own medications**. This form is solely for the purpose of ADMINISTRATION. In no way does this form preclude the need for doctor check-ups or prescriptions, nor does this form preclude the need for yearly health appraisals. We reserve the right to withhold medication if, in our estimation, we feel that it is necessary that his/her physician see the child.

| Date | Time | Printed Name of Staff Member that Administered | Adverse Effects or Errors |
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