



Medical Authorization Form

Prescription and Non-Prescription
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	Expiration Date	Time		Dosage	Route		
RX #		<input type="checkbox"/>	_____		<input type="checkbox"/> Ear (R/L)		
		<input type="checkbox"/>	_____		<input type="checkbox"/> Nose		
Medication Directions (per label)					<input type="checkbox"/> Mouth		
Possible Reactions					<input type="checkbox"/> Eye (R/L)		
Prescribing Physician					<input type="checkbox"/> Topical		
Pharmacy				Pharmacy Phone			
<i>I give authorization to dispense medication listed above in accordance with the written directions on the prescription label or printed manufacture's label. This authorization form must be maintained and is only valid for the duration of the prescription.</i>							
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