# Medication Authorization Form

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| **Child's Name:** | **Date of Birth/Age:** |
| **Name of Medication:** | **Reason for Medication:** |
| **Start Date:** | **Stop Date:** |
| **Times to be given:**<br>(*Can NOT be given "as needed") | **Amount to be given:** |
| **Possible Side Effects:** | ❑ **Oral** ❑ **Topical** ❑ **Other** |
| ❑ **Above information consistent with label?** | **Requires Refrigeration:** ❑ **yes** ❑ **no** |
| **Special Instructions:** | |

**Parent/Guardian Signature** **Date**

**Daytime Phone Number**

**Physician Signature** **Date**

**Physician Phone Number**

❑ *Medications returned to parents or discarded*
*(must be completed after stop date and before filing form in child's file)*