Authorization to Give Medication

I certify that, in my opinion, it is medically necessary that the medication prescribed below be administered to _____ during center hours and that this medication may be administered by center staff.

Prescription	Medication	Prescription Date _____/_____/_____
	Dosage and Time	
	Duration	Expiration Date _____/_____/_____
	Reason for Medication	
	Side Effects or Adverse Reactions to Look For:	

_____
Physician Signature

_____/_____/_____
Date

I, _____, the parent or guardian of _____ request that center staff administer the medication prescribed above to my child during center hours. I understand that the person who will administer the medication has been trained in medication administration. I also agree to furnish the above medication in the container supplied by the pharmacy with the label intact.

_____
Signature of Parent/Guardian

_____/_____/_____
Date

This agency will not give any “as-needed” medications.