



## Medication Authorization Form

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

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Phone Number

