Emergency Medication Authorization Form

Child's Name: _____

Medication Name*/Strength: _____

Dosage Amount/Frequency: _____

How to be Given: _____Oral _____Topical _____Other

Time to be Given: _____ Date(s) to be Given:_____

Symptoms Indicating Need for Administration: _____

_____

Actions to Take Once Symptoms Occur: _____

_____

Side Effects/ Anticipated Reactions: _____

_____

_____ _____

Parent's Signature Date

If all information is not filled in completely, medication will not be given.

Administration Documentation**

Date Given	Time Given	Dosage Given	Signature of Person Administering Medication

Staff Completing Form:_____

** Medication should be in original container*
*** Documentation shall be updated by parent as changes occur or at least every six months*