Public Health
Seattle & King County

Medication Authorization Form for Chronic Conditions

(Asthma medications, Insulin or Skin Creams/Lotions for Eczema, etc.)

Child's Name:	**Date of Birth:**
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:	**Oral** ☐ **Topical** ☐ **Other** ☐ **If other, explain:**
Above information consistent with label? ☐ **Yes** ☐ **No**	**Requires Refrigeration?** ☐ **Yes** ☐ **No**
Special Instructions:	

_____ _____

Parent/Guardian Signature **Date**

( ) _____

Daytime Phone Number

_____ _____

Physician Signature **Date**

( ) _____

Physician Phone Number

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Medication Record for Chronic Conditions

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Comments:

Signatures that correspond to initials of persons giving medication:

_____ _____

_____ _____