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:	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

Medication Record

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

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

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_____ ________________________ _____ ________________________

Public Health
Seattle & King County