Submit Form

MEDICATION AUTHORIZATION

_____ staff members may administer _____
(name of center) *(name of medication)*

to my child _____. The dosage to be given is _____
(child's name) *(amount)*

It is to be given at _____. This is to be continued for _____
(time to be given) *(# of days)*

days between _____ and _____.
(date) *(date)*

_____ _____
(parent signature) *(date)*

VERIFICATION

Date	Time	Amount	Person Administering