

Medication Authorization Form

For Prescription and Non-prescription Medications



INSTRUCTIONS:

Section A must be completed by the parent/guardian for **ALL** medication authorizations.

Section A and Section B must be completed for any **long-term medication authorizations** (those lasting longer than 10 consecutive days).

Section A: To be completed by parent/guardian

Medication authorization for: _____

(Child's name)

Open Arms Christian Child Development Center has my permission to administer the following medication:

Medication name: _____ Route: _____

Dosage: _____ Times to be administered: _____

Special instructions (if any): _____

Child's known allergies: _____

This authorization is effective from: _____ until: _____

(Start date)

(End date)

Parent or Guardian's Signature: _____ Date: _____

Section B: To be completed by child's physician

I, _____ certify that it is medically necessary for the medication listed

(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 consecutive days.

(Child's name)

Medication name: _____ Route: _____

Dosage: _____ Times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____

(Start date)

(End date)

Physician's Signature: _____ Date: _____

Physicians Phone: _____ Fax: _____

Open Arms Admin Signature: _____ Date: _____