Parent/Guardian Consent

Medication Authorization Form

**Medicine Must Be In Its Original Container**

Child's Name:

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name/Strength: Dosage Amount/Frequency: How to be Given: Oral Topical Other: Time to be Given: Date(s) to be Given: Side Effects/ Anticipated Reactions:

Special Instructions (If Applicable or “as needed” medication”):

***Other persons to be notified in case of emergency:***

***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Parent/Guardian's Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Staff Member’s Signature Date

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

**\*\* Weekly medication-form must be completed weekly\*\***

**\*\*\* PRN/Emergency medication-must be completed by parent every 6 months (or child**

 **will be excluded from attending) or as changes occur \*\*\***