

Central Academy & Child Care
DIRECTED MEDICATION AUTHORIZATION FORM
Medication must be in its original container

Child's Name: _____

Medication Name: _____

Dosage Amount: _____

Date(s) To Be Given: _____

Side Effects/Anticipated Reactions: _____

Special Instructions (If Applicable): _____

Medication WILL NOT be given if form is incomplete

Parent's Signature

Date

Administration Documentation

Date Given	Time Given	Dosage Given	Staff Signature

This form must be updated if changes occur.