



## MEDICAL AUTHORIZATION FORM

I **authorize** the administration of

\_\_\_\_\_ to \_\_\_\_\_  
(medicine) (name of child)

By staff members (at least two)

1) \_\_\_\_\_

2) \_\_\_\_\_

Starting Date: \_\_\_\_\_

Completion Date: \_\_\_\_\_

To be administered using the following instructions:

1) Dosage \_\_\_\_\_

2) Specific time or circumstances to be given:  
\_\_\_\_\_

3) Give this medication if the following is observed:  
\_\_\_\_\_

4) Storage Instructions: \_\_\_\_\_  
\_\_\_\_\_

5) Additional Instructions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent signature)

\_\_\_\_\_  
(Director signature)

\_\_\_\_\_  
(Parent signature)

\_\_\_\_\_  
(Staff signature)

\_\_\_\_\_  
(Staff signature)