



Medication Authorization Form

Only medications permitted are liquid Benadryl, asthma inhaler, and EpiPen

Section A: To be completed by parent/guardian - Instructions: Section A must be completed by the parent/guardian for ALL medication authorizations.

Medication authorization for: _____
(Child's name)

_____ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Parent's or Guardian's Signature: _____ Date: _____

Section B: to be completed by child's physician - Section B must be completed for any long-term medication authorizations (those lasting longer than 10 working days).

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)
below to be administered to: _____ for a duration that exceeds 10 work
days. (Child's name)

Medication(s): _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Physician's Signature: _____ Date: _____

Physician's Phone: _____