



Weekly Medication Authorization Form

Child's Full Name _____ Class _____

Medication Name _____ Rx # _____

Time Medication is to be given: 12 noon 4pm

Dosage _____

How is medication to be administered? _____ Orally _____ Topically applied to skin

Dates to be given _____ through _____

Signature (Parent/Guardian)

Date

For Center Use:

	Date	Time Given	Amount	Any Adverse Reactions	Administered by
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe.

