MOUNTAIN VIEW PREP

2320 Baker Road • Acworth, GA 30101
phone (770) 218-1950 • *fax* (770) 218-0628

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____

(Medication will NOT be given on an "AS Needed" basis; specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

_____ _____

PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e.: child absent, medication not sent, child sleeping, etc .....)

DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	ADMINISTERED BY
1.				
2.				
3.				
4.				
5.				
6.				
7.				

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

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in its entirety before the center can dispense any medication.