Medication Authorization

Section I: Physician's Instructions

(Name of child) ____ should receive *(name of medicine, vitamin, or modified diet)* as follows: ______________________________________

____

Specific instructions for administration: ____

Possible side effects to watch for:____

Signature of Physician	Date of Signature	Telephone Number

Note: If medication or vitamin is a prescription from pharmacy, physician's instructions and signature will not be required. Instead of having the above section completed, the parent completes the chart below:

Rx Number	Pharmacy
Street Address	Telephone Number

Section I does not need to be completed for certain non-prescription items: fever-reducing medicines that do not contain aspirin; cough or cold medications that do not contain codeine; and topical ointments, creams or lotions.

Section II: Parent/Guardian Request for Administration of Medicine or Vitamin

I hereby request and give permission to the Gabina Learning Center Director to administer the following medication or vitamin to my child:

Name of Child	Name of Medication	Dosage	Time(s) to be given

Signature of Parent	Date of Signature