Medication Authorization/Modification Form

Select One:

- ☐ Medication Authorization
- ☐ Medication Modification
- ☐ Medication Discontinuation Effective Date: _____/_____/_____

Child's Name	
Medication Name:	
Dosage Amount::	
Time to be Given:	
Date(s) to be Given:	
Side Effects/Anticipated Reactions	
Special Instructions/Circumstances for Administrating "as needed" medication (if applicable):	

_____ _____

Parent's Signature Date

Please note the following requirements, if not followed, will result in medication not given.

- Medication **MUST** be in its original container.
- Medication must bear a printed label clearly stating the name of the child to whom the medication has been prescribed .
- All information above **MUST** be completed.
- Medication Authorization/Modification Form to be updated, by parents, as changes occur or at least or at least every three months.

Please complete a different form for each child.