Public Health
Seattle & King County

# Medication Authorization Form

| **Child's Name:** | **Date of Birth/Age:** |
|---|---|
| **Name of Medication:**<br><br>**Expiration Date:** ____/____/____ | **Reason for Medication:** |
| **Medication Start Date:** ____/____/____ | **Medication Stop Date:** ____/____/____ |
| **Times to be given:**<br><br>(CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication) | **Amount to be given:** |
| **Possible side effects:** | **Route:**<br><br>☐ **Oral** ☐ **Topical** ☐ **Other**<br>**Requires Refrigeration:** ☐ **Yes** ☐ **No** |
| **Above information consistent with label?** ☐ **Yes** ☐ **No** | |
| **Special Instructions:** | |

______________________________ (_____)______________________
**Health Care Provider Name** (please print) **Phone Number**

______________________________ ______________________________
**Health Care Provider Signature** **Date**

______________________________ (_____)______________________
**Parent/Guardian Name** (please print) **Phone Number**

______________________________ ______________________________
**Parent/Guardian Signature** **Date**

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# Medication Record

(Must be filled out by the person who gives the medication)

| **Child's Name:** |
| --- |
| **Name of Medication:** |

| Date | Time | Dosage | Initials | Reason NOT Given | Side Effects Observed |
| --- | --- | --- | --- | --- | --- |
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**Initials and signatures of persons giving medication:**

____ ______________________________ ____ ______________________________

____ ______________________________ ____ ______________________________

Child Care Health Program
Revised 3/2022