

MEDICATION AUTHORIZATAION

I certify that, in my opinion, it is medically necessary that the medication described below be administered to \_\_\_\_\_ during center hours and that this medication may be administered by center staff.

Perscription: Medication: \_\_\_\_\_

Dosage and Time: \_\_\_\_\_

Duration: \_\_\_\_\_

Date of Prescription: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Physician)

-----  
I \_\_\_\_\_, the parent or guardian of

\_\_\_\_\_, request that center staff administer the medication prescribed above to my child during center hours. I understand that the person who will administer the medication may be inexperienced. I also agree to furnish said medication in the container supplied by the drug store with the label intact.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)