

## Medication Authorization

Child's Name: \_\_\_\_\_

Physician Authorization Start Date: \_\_\_\_\_

Physician Authorization End Date: \_\_\_\_\_

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

Dose and Directions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Name (please print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Administration record:

Date	Time	Comments	Staff initials
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