

St. Patrick's Episcopal Day School

Medication Authorization Form

MEDICATION MUST BE IN ITS ORIGINAL CONTAINER

Child's Name: _____

Medication Name: _____

Dosage Amount: _____

Times to be Given: _____

Date(s) to be Given: _____

Side Effects/Anticipated Reactions: _____

Special Instructions (if applicable): _____

Parent's Signature

Date

***If all information is not filled in completely, medication will not be given.**

***We will not administer a "first ever" dose of any medication**

Date Given	Time Given	Dosage Given	Administering Staff Signature	Observing Staff Signature

*Maintenance medication authorization shall be updated as changes occur or at least every three months.