

AUTHORIZATION FOR DISPENSING MEDICATION

PARENT'S AUTHORIZATION

| | | | |
|-----------------------------------|------------------|----------------------------------|--|
| Name of Child to Receive Medicine | | Name of Medication | |
| Prescribing Physician | Prescription No. | Expiration Date | |
| Dosage | When to Give | Continue Medication Until (date) | |

NOTE: Medication must be in its original container and labeled with your child's name and the date medication is left at the facility. Medication can only be administered in amounts according to the label directions.

_____ Signature-Parent or Guardian _____ Date

CAREGIVER'S RECORD OF ADMINISTERING MEDICATION

| CHILD'S NAME | NAME OF MEDICATION | DATE GIVEN | TIME GIVEN | AMOUNT GIVEN | FULL NAME OF CAREGIVER OR EMPLOYEE |
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| Disposition of Left-over Medication |
| <input type="checkbox"/> Returned to Child's Parent/Guardian <input type="checkbox"/> Thrown Away Date: _____ |