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AUTHORIZATION TO ADMINISTER MEDICATION

Patient:_____ Birthdate:_____

Name of Medication:_____

Pharmacy:_____

Health Condition:_____

Please administer the above medication as follows:

Amount:_____

Time:_____

Starting Date:_____ Ending Date:_____

Amount Sent:_____

I request that the prescribed drugs or medication be administered according to these written directions. I request that this medication be given by a qualified staff person. The patient has experienced no previous side effects from this medication. I further agree that administering personnel may contact the prescriber as needed and that medication information may be shared with administering personnel who need to know.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name (printed):_____

Home Phone #:_____ Work Phone #:_____

Cel Phone #:_____