Authorization for Dispensing Prescription Medication

PARENTS AUTHORIZATION

Name of Staff Members Authorized to Give Medication:	**Name of Child to Receive Medicine:**	
Prescribing Physician:	**Prescription No.:**	**Name of Medication:**
Dosage:	**When to Give:**	**Continue Medication Until (date):**
Route:	**Storage Conditions:**	**Special instructions:**

Note: Medicine must be in original labeled container. I give me permission for the named staff members or director to administer this medication to my child.

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Signature – Parent or Guardian **Date**

CAREGIVER'S RECORD

DATE	TIME	AMOUNT	DATE	TIME	AMOUNT

DISPOSITION OF LEFT OVER MEDICATION: DATE RETURNED/DISCARDED

ف Returned to Parent ف Thrown Away _____