

# Medication Authorization Form

For Prescription and Non-prescription Medications



## INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 days).

### Section A: To be completed by parent/guardian

Medication authorization for: \_\_\_\_\_

*(Child's name)*

\_\_\_\_\_ has my permission to administer the following medication:

*(Name of Parent/Guardian)*

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

Dosage and times to be administered: \_\_\_\_\_

Special instructions (if any): \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until: \_\_\_\_\_

*(Start date)*

*(End date)*

**Parent's or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Section B: to be completed by child's physician

I, \_\_\_\_\_ certify that it is medically necessary for the medication(s) listed

*(Name of Physician)*

below to be administered to: \_\_\_\_\_ for a duration that exceeds 10 days.

*(Child's name)*

Medication(s): \_\_\_\_\_

Dosage and Times to be administered: \_\_\_\_\_

Special instructions (if any): \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until: \_\_\_\_\_

*(Start date)*

*(End date)*

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physicians Phone: \_\_\_\_\_