Authorization to Dispense Medication

Facility Information

Childcare Program Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Telephone number: ____________________

Child's Information

Child's Name: ____________________

Name of Medication: ____________________

Prescription Number: ____________________

Physician's Name: ____________________

Date(s) to give medication: ____________________

Time of day medication is to be given	a.m. or p.m.	a.m. or p.m.	a.m. or p.m.	a.m. or p.m.

How medication is to be stored: ____________________

Parent/Guardian Name: ____________________

Parent/Guardian Signature: ____________________

Parent/Guardian Name: ____________________

Parent/Guardian Signature: ____________________

Medication Record to be completed by Child Care Provider

Date	Time (a.m. or p.m.)	Amount (Dosage)	Any Adverse Reaction	Signature of person giving medication
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	

If adverse reaction to medication was noted, please describe action taken: ____________________