Medication Authorization Form

Section A to be completed by parent/guardian

I,_____ , authorize Beth Emeth Early Childhood Center to administer the following medication for my child, _____

Medication name:_____

Dosage: _____Time(s) to be administered:_____

Special instructions (if any):_____

_____

This authorization is effective from:_____ until:_____

Parent/Guardian signature:_____ Date:_____

Section B to be completed by child's physician

I,_____ , authorize Beth Emeth Early Childhood Center to administer the following medication for my child, _____

Medication name:_____

Dosage: _____Time(s) to be administered:_____

Special instructions (if any):_____

_____

This authorization is effective from:_____ until:_____

Physician Signature:_____

Physician Phone Number:_____Date:_____