Medication Authorization Form

Please note you must fill out a separate form for each medication you are authorizing Children's Corner to administer:

OVER THE COUNTER MEDICATION

(This includes, cough drops, Tylenol, Oragel, Lotions, Sunscreen, Antihistamines, etc…)
Physician's Signature is NOT REQUIRED for over the counter medication.
(All information in this section is required)

Name of Medication___________________________ Strength of Medication_______________________

Time to be administered_________________________________ Dosage__________________________

Special Instructions____

____

PRESCRIPTION MEDICATION

(This includes all medication ordered by a Physician)
Requires a Physician's Signature
(all information in this section is required)

Name of Medication___________________________ Strength of Medication_______________________

Route___________________ Dosage_________________________ Frequency______________________

Possible Side Effects:____

Special Instructions____

____

Physician's Signature:____ Date:____________

Address:____ Phone:___________________________

PARENT AUTHORIZATION

I hereby grant permission for non-medical support staff of Children's Corner to give (Student Name) ______________________________ the above named medication as indicated/prescribed. I agree to provide the medication in the original bottle which is properly labelled by the pharmacy/store. The bottle will also have my child's name written in permanent marker on it. The medication will be kept in the school office, and the student will report to the office to receive the medication. I understand that students are not allowed, under any circumstances to have medications in their possession while at Children's Corner.

Parent/Guardian Signature:_______________________________________ Date:_____________________