



## Authorization for School / Day Care to Administer Medication

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time to be Given: \_\_\_\_\_

Effective Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_