

Ambrose Family Center
Webster Groves School District

MEDICATION AUTHORIZATION

Child's Name _____ DOB _____

MEDICATION REQUIREMENT:

Prescription medicine shall be in the original container and labeled with the child's name, instructions, including times and amounts for dosages, and the physician's name. All non-prescription medicine shall be in the original container and labeled by the parent(s) with the child's name and instructions for administration, including times and amounts for dosages. A separate form is needed for each medication. This form is valid only for the dates indicated below.

I authorize Early Childhood Education Center personnel to administer the following medication to my child: (list proper name of medication)		Date on Prescription
Medication Start Date:	Medication Completion Date:	
Condition for which the medication is prescribed:		
Dosage:	Time(s) of Day (give specific time(s):	
Possible side effects:		
Signature of Parent(s)/Guardian(s):		Date:

Record of Administration					
Administered by (staff name)	Date	Medication Name	Dosage	Time	Any Reaction

