MEDICATION AUTHORIZATION FORM

For Prescription and Non-Prescription Medications

- **Section A must be completed by the parent/guardian for ALL medication authorizations**
- **Additionally, Section B must be completed by the child's physician for any long-term medication authorizations (those lasting longer than 10 working days), any Epinephrine or Nebulizer use, and those whose dosage directions state "consult a physician".**
- Medication must be in the original container, and prescription medication must be clearly labeled with the full pharmacy label (including the child's full name, medication name, and time, dosage, and duration of administration).
- All medication must be picked up by the parent within 14 days of the authorization expiration date.

Section A: To be completed by parent/guardian

_____ _____ _____
(Child's First and Last Name) (Date of Birth) (Gender)

The Learning Village Montessori has my permission to administer the following medication:

Medication name (including strength): _____

Dosage to be administered: _____ Time(s) to be administered: _____

Observable/measurable symptoms that will necessitate the administration of as-needed medication:

_____

Possible Side Effects: _____
(*Parents must supply package insert or pharmacy printout for complete list of possible side effects)*

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____ *(not to exceed one year)*
(Start Date) (End Date)

Parent's or Guardian's Signature: _____ Date: _____

Section B: To be completed by child's physician

_____ _____ _____
(Child's First and Last Name) (Date of Birth) (Sex)

I certify that it's medically necessary for the medication to be administered for more than 10 working days:

Medication name (including strength): _____

Dosage to be administered: _____ Time(s) to be administered: _____

Observable/measurable symptoms that will necessitate the administration of as-needed medication:

_____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____ *(not to exceed one year)*
(Start Date) (End Date)

Name of Physician: _____ Physician's Phone: _____

Physician's Signature: _____ Date: _____