Short Term Medication Authority

This Medication Authority is to be completed for medication administered on a temporary basis. A new form should be completed each day that medication is required. All medication must have a Doctor's label or an accompanying Doctor's letter.

Date: ___/___/___ Child Name: _____ DOB: ___/___/___

Name of Medication: _____ Dosage to be administered: _____

Conditions which requires medication: _____

Time span for medication: From: ___/___/___ (date) to ___/___/___(date) Times to be Administered: _____

Date medication last administered: _____ Time medication last administered: _____

Name of prescribing doctor: _____ Telephone: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____ Date ___/___/___

Team Member Signature: _____ Date ___/___/___

(Team Member Use Only)

Date: ___/___/___ Time Medication Administered: _____am/pm

Name of Medication: _____ Dosage Administered: _____

Name of Team Member administering medication:_____

Signature of Team Member administering medication: _____

Name of Witness: _____ Signature of Witness: _____

Date: ___/___/___ Time Medication Administered: _____am/pm

Name of Medication: _____ Dosage Administered: _____

Name of Team Member administering medication:_____

Signature of Team Member administering medication: _____

Name of Witness: _____ Signature of Witness: _____