**PARENT’S AUTHORIZATION**

**Note: All Medication must be in original labeled container.**

|  |
| --- |
| **Name of Child to Receive Medication:** |
| **Prescribing Physician:** | **Prescription No.:** | **Name of Medication:** |
| **Dosage:** | **When to Give:** | **Continue Medication Until:** | **Expiration Date:** |
| **Route:** | **Storage Conditions:** | **Special Instructions:** |

 **Signature of Staff who received and approved medication form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature-Parent or Guardian Date**

**CAREGIVER’S RECORD**

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| --- | --- | --- | --- | --- |
| **Date** | **Time of Last Home Dosage** | **Dosage** | **Time** | **Initial** |
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**Parent's Initial when Medication is sent home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**