**Medication Authorization and Administration Form**

***To be completed by a parent before any medication is administered by a provider.***

I authorize the administration of Click or tap here to enter text. to Click or tap here to enter text. by Click or tap here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| Specific Time of Administration | Signs and Symptoms | Dosage | Relevant side effects observed, if any |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

The authorization is in effect until: Click or tap to enter a date.

Medication is to be stored: Click or tap here to enter text.

X

Parent Signature:

Date: Click or tap to enter a date.

**Administration Record:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Given** | **Time Given HH.MM am/pm** | **Amount Given** | **Comments** |
| Date Given | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Date Given | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Date Given | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Date Given | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

X

**Provider Signature:**