

# EMERGENCY Medication Authorization Form

Medicine Must Be in its **ORIGINAL** Container

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

How to administer: **ORAL TOPICAL INJECTION RECTAL**

Symptoms indicating need for administration: \_\_\_\_\_

Actions to take once symptoms occur: \_\_\_\_\_

Side effects/anticipated reactions: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*If all information is not filled in completely, medication will not be administered.\*\***

## Administration Documentation

Date	Time	Dosage	Symptoms Observed	Actions Taken	Staff Signature	Parent Contact

**\*\*Shall be updated by parent as changes occur or at least every 6 months\*\***

Signature of Staff: \_\_\_\_\_

Date: \_\_\_\_\_