A Child's Delight Learning Center

Medication Authorization and Dispense Form

Child's Name: _____

Health Problem: _____

Name of Medication: _____Course: _____

Possible side effects: _____Storage: _____

Amount of Medication Given: _____Times: _____

Start Date: _____ End Date: _____

_____ Medication was discarded or given back to Parent? (Please circle)

I authorize A Child's Delight Learning Center staff members to give the above medication.

_____ _____

Parent/Guardian Full Signature Date

Record of Administration (To be filled out by person who gives medication)

DATE	TIME	DOSAGE	GIVEN BY (full Signature required

If reaction to medication:

DATE	ACTION TAKEN

*Form to be placed in child's file when complete