Medication Authorization & Dispense Form

Child's Name _____

Health Concern _____

Name of Medication _____

Possible Side Effects _____

Medication Route (Circle One) Oral Topical Other _____

Dosage Amount _____ Expiration Date _____

Start Date _____ Stop Date _____

Time To Be Given _____ Last Time Given _____

Record of Administration

To be completed by individual who administers medication.

	DATE	TIME	DOSAGE	GIVEN BY (Full Signature)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Reaction to Medication

Date/Time _____

Action Taken _____

I authorize Cornerstone ECE to administer the medication listed above.

Parent/Guardian (Full Signature) Date

Emergency Contact Phone #1 Emergency Contact Phone #2