KING'S CHILDREN'S CENTER
Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Start Date:	Stop Date:
Times to be given: (*Can NOT be given "as needed")	Amount to be given:
Possible Side Effects:	☐ Oral ☐ Topical ☐ Other
Above information consistent with label?	Requires Refrigeration: ☐ yes ☐ no
Special Instruction:	

Parent/Guardian Signature _____ Date _____

Daytime Phone Number _____

Physician/Health Care Provider Signature _____ Date _____

Physician/Health Care Provider Phone Number _____

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MEDICATION RECORD

(Must be filled out by the person who gives the medication)

Child's Name:
Name of Medication:

Medicine in Original Packaging?	Yes ❒	No ❒	Expiration Date Current?	Yes ❒	No ❒
Child's Full Name Printer on Container?	Yes ❒	No ❒	Age-Appropriate Dosage Indicated?	Yes ❒	No ❒
Refrigeration Necessary?	Yes ❒	No ❒			

DATE	TIME	DOSAGE	INITIALS	REASON NOT GIVEN	SIDE EFFECTS OBSERVED

Signatures that correspond to initials of persons giving medication:

_____ _____

_____ _____

_____ _____

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