MEDICATION AUTHORIZATION

I authorize the administration of:

MEDICATION:______________________________

TO: ______________________________________

(Child's Name)

BY: ☐ **Cook's Home Child Care Agency**

Provider: ____________________

☐ **Victoria Park Child Care Centre**

START DATE: (D)____ (M)____ (Y)____

END DATE: (D)____ (M)____ (Y)____

ADMINISTRATION INSTRUCTIONS

DOSAGE	TIME/S

Medication should be administered when the following symptoms are observed:

____

____

____

Stop medication if the following reaction or side effects are observed:

____

____

____

STORAGE: ☐ **Refrigerated**

☐ **Non-Refrigerated**

SIGNATURE:______________________________

(Parent/Guardian)

DATE: (D)____ (M)____ (Y)____

RECORD OF ADMINISTRATION

DATE			TIME GIVEN	AMOUNT GIVEN	STAFF SIGNATURE	COMMENTS
D	M	Y				