

Medication Authorization Form
(Prescription and Non-prescription Medications)



INSTRUCTIONS:

- Section A must be completed by the parent/guardian for **ALL** medication authorization
- Section B must be completed by the physician prescribing the medication
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 days).
- This authorization is valid from the date below through the end of the current school year.
- A separate form must be used for each medication

Section A: To be completed by parent/guardian

Medication authorization for: (First Name) _____ (Last Name) _____
(Child's Name)

Fairfax United Methodist Church Preschool has my permission to administer the following medication:

Medication: _____

Dosage and time to be administered: _____

Special instructions (if any): _____

Child's known allergy/illness: _____

Symptoms: _____

Parent or Guardian's Signature: _____ **Date:** _____

Parent/Guardian First Name: _____ Last Name: _____ Phone: _____

Section B: To be completed by child's physician

The undersigned certifies it is medically necessary for the medication listed below be administered to

(First Name) _____ (Last Name) _____
(Child's Name)

Medication: _____

Dosage and time to be administered: _____

Special instructions (if any): _____

Child's known allergy/illness: _____

Symptoms: _____

Physician's Signature: _____ **Date:** _____

Physician's First Name: _____ Last Name: _____ Phone: _____



Medication Log

Child's Name _____

Medication: _____

Date/Time (AM/PM)	Administered by (Sign & print)	Dosage	PRN Symptoms exhibited	Side Effects
1.				
2.				

Complete section below for Medication Errors
(if this medication was not given as written on the child's written consent form.)

Date of Error	Details of medication error (include reason error occurred)	Parents notified	Signature (Sign & print)
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If an incident was reported to State of Virginia: Incident Number: _____

Date Reported: _____

Name of representative who took report: _____

Phone No. _____