PRESCRIPTION MEDICATION AUTHORIZATION

CHILD'S FIRST & LAST NAME:	BIRTHDATE	TODAY'S DATE

NAME OF MEDICATION:	REASON FOR MEDICATION:

DOSAGE TO BE GIVEN:	NUMBER OF PILLS RECEIVED: (CONTROLLED SUBSTANCES ONLY)

DATES MEDICATION IS TO BE GIVEN:

TIME(S) MEDICATION IS TO BE GIVEN:

POSSIBLE SIDE EFFECTS:

NAME HEALTH CARE PROVIDER:	PROVIDER'S PHONE NUMBER

SIGNATURE OF PRESCRIPTIVE AUTHORITY:

Label checked for first and last name of child (use tape if necessary), date, name of health care provider who made recommendation, and specific legible instructions for administration and storage of the medication.	☑ CHECKED

This constitutes my written authorization for Saint Joan of Arc ELC staff to administer the medication described above at the times indicated. Only Oral or externally applied medication will be administered. Times for administering medication must be definite, as it cannot be administered "as needed."

PARENT'S SIGNATURE:

AREA BELOW FOR STAFF USE ONLY

ADMIN.BY: (SIGNATURE.)						
TIME ADMIN.						
DATE ADMIN.						
COMMENTS AND/OR SIDE EFFECTS NOTED						