

Bright from the Start
Georgia Department of Early Care and Learning

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____

(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

PARENT'S SIGNATURE

DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)

	<u>DATE</u>	<u>TIME GIVEN</u>	<u>AMOUNT</u>	<u>ANY ADVERSE REACTIONS</u>	<u>ADMINISTERED BY</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication