Public Health
Seattle & King County

Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication: Expiration Date: ___/___/___	Reason for Medication:
Medication Start Date: ___/___/___	Medication Stop Date: ___/___/___
Times to be given: (CANNOT be given "as needed;" must specify time of day and/or symptom for which to give medication)	Amount to be given:
Possible side effects:	Route: ☐ Oral ☐ Topical ☐ Other
☐ Above information consistent with label?	Requires Refrigeration: ☐ Yes ☐ No
Special Instructions:	

Health Care Provider Name (please print) ______________________ Phone Number (___)______________

Health Care Provider Signature ______________________ Date ______________

Parent/Guardian Name** (please print) ______________________ Phone Number (___)______________

Parent/Guardian Signature ______________________ Date ______________

Public Health
Seattle & King County

Medication Record

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

Child's Name:
Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

____ ____________________ ____ ____________________

____ ____________________ ____ ____________________

Child Care Health Program
Revised 9.2018