Medication Authorization and Administration

Child's Name: ___________________________

Name of Medication	Expiry Date (if applicable)	Dosage	Time of Day	Start Date	End Date	Storage Dry / Cold

Dosage and time of day must match the prescription label (ie: if label states 4x/day, specify exact time that medication is to be administered. If inhaler label states 2-4 puffs and parent requests the lower dose, parent must give instruction on what symptoms to look for to give remaining dosage.)

Diagnosis/Symptoms: ___________________________

Possible Side Effects: ___________________________

For further information, please refer to my child's:

- ☐ Anaphylaxis Action Plan
- ☐ Asthma Action Plan
- ☐ Seizure Action Plan
- ☐ Diabetes Action Plan
- ☐ Medical Emergency Action
- ☐ **N/A**

Storage Location

I fully understand that I or my backup person have no special training and are not liable for any result that may occur as a consequence of the administration, or failure to administer as the case may be, of such medication.

___________________________ ___________________________

Parent/Guardian Signature Date

For Internal Use Only

Date	Time	Dosage	Reason for Administration	Observations	Provider Signature

A note must be made in the Daily Written Record each time medication is administered.

Annual Review (if applicable)

I have reviewed the above mediation information and confirm that all details remain accurate.

___________________________ ___________________________

Parent / Guardian Signature Review Date

Medication Administration Record

Date	Time	Dosage	Reason for Administration	Observations	Provider Signature