



MEDICAL AUTHORIZATION

NOTE: This form must be completed in its entirety before Homestead staff can administer any medication.

Child's Name: _____

Name of Medication: _____

Prescription Number: _____

(Specify if medication is over the counter)

Time Medication is to be given: _____

(Medication will not be give on an "as needed" basis)

Amount of medication to be given: _____

Dates to be given: _____

(Cannot exceed 2 weeks without a physician's statement)

Parent's Signature: _____

Date: _____

For Homestead Use

**Document reasons medication is not given as parent requested
(eg. child late or absent, medication not brought, etc.)**

Date	Time	Amount	Any Adverse Reactions	Given By

Please list any noticeable adverse effects to the medication and what action was taken.

