Growing Room
CHILD DEVELOPMENT CENTERS

Weekly Medication Authorization Form

Child's Full Name_____ Class_____

Medication Name_____ Rx #_____

Time Medication is to be given: 12 noon 4pm

Dosage_____

Dates to be given_____ through_____

_____ _____
Signature (Parent/Guardian) Date

For Center Use:

	Date	Time Given	Amount	Any Adverse Reactions	Administered by
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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

_____
_____
_____
_____