Hope Children's Center
MEDICATION AUTHORIZATION FORM

Staff Member Authorized to Give Medicine		Name of Child to Receive Medicine
Name of Medication	Prescription #/Date	Prescribing Physician
Dosage	Where to Give	Continue Medication Until (date)

NOTE: Medicine must be in its original container labeled with the child's name.

By signing below, I release Hope Children's Center from all liability for reactions which my child may suffer from this medication.

Signature____________________ Date______________

DATE	TIME	DOSAGE GIVEN	STAFF ADMINISTERING MEDICATION