§1917.H,K

Emergency Medication Authorization Form

Medicine Must Be In Its Original Container

Child's Name: _____

Medication Name: _____

Dosage Amount: _____

How to Be Given: Oral Topical Other: _____

Symptoms Indicating Need for Administration: _____

_____

Actions to Take Once Symptoms Occur: _____

_____

Side Effects/ Anticipated Reactions: _____

_____

_____ _____

Parent's Signature Date

***If all information is not filled in completely, medication will not be given.**.

Administration Documentation

Date Given	Time Given	Dosage Given	Symptoms Observed	Actions Taken	Staff Signature	Phone Contact w/whom Time & Date

shall be updated by parent as changes occur or at least every six months

_____ _____

Signature of Staff Completing Form Date