MEDICATION AUTHORIZATION FORM

For Prescription and Non-prescription Medications

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: ***(Child's name)***____

___________________________________has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name:____

Dosage and times to be administered:____

Special instructions (if any):____

This authorization is effective from: _____/_____/_____until:_____/_____/_____

Parent's or Guardian's Signature:____

Date: _____/_____/_____

Section B: to be completed by child's physician

I, _________________________________certify that it is medically necessary for the medication(s) listed
(Name of Physician)
below to be administered to: ____________________________ for a duration that exceeds 10 work days.
(Child's name)
Medication(s):____

Dosage and Times to be administered: ____

Special instructions (if any): ____

This authorization is effective from: ____/____/____ until: ____/____/____

Physician's Signature: ____

Date: ____/____/____ **Physicians Phone:** ____

AlphaBEST Manager's Signature:____ **Date:**____/____/____