



I'll Be Your Best Friend Academy

AUTHORIZATION FOR MEDICATION

Child's Full Name _____

Name of Medication _____

Prescription Number _____

Time Medication is to be Given _____

Amount of Medication to be Given _____

Dates to be Given _____

Signature (Parent/Guardian)

Date

For Center Use

	Date	Time Given	Amount	Any Adverse Reactions	Administered By
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

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

