

§1917.H,I

**As Needed Medication Authorization Form**

Child's Name: \_\_\_\_\_

Medication Name\*/Strength: \_\_\_\_\_

Dosage Amount/Frequency: \_\_\_\_\_

How to be Given:      Oral                      Topical                      Other: \_\_\_\_\_

Time to be Given: \_\_\_\_\_

Date(s) to be Given: \_\_\_\_\_

Side Effects/ Anticipated Reactions: \_\_\_\_\_

\_\_\_\_\_

Special Instructions/Circumstances for Administering As Needed Medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 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	Signature of Person Administering Medication

\_\_\_\_\_

Signature of Staff Completing Form

*\*medication should be in its original container*

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