



### Authorization for Dispensing Medications

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. Non-prescription medications can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth according to the instructions on the label.

#### Medication #1

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

( \_\_\_\_\_ )  
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

#### Medication #2

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

( \_\_\_\_\_ )  
\_Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

**Medication #3**

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

**Medication #4**

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

(\_\_\_\_\_) \_\_\_\_\_  
\_Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

**Medication #5**

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

**Medication #6**

\_\_\_\_\_  
First and Last Name of Child/Youth Date of Birth

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Reason for Medication

\_\_\_\_\_  
Dose                      Time to be Given                      Stop Date

\_\_\_\_\_  
Name of Licensed Physician/PA/APRN prescribing the medication

(\_\_\_\_\_) \_\_\_\_\_  
\_Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

\_\_\_\_\_  
Parent's Signature Date

### Nurse's Medication Record Form

This form is to be used to document the administration of only the medication(s) identified above.

Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form. \*Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date <u>mm/dd/yy</u>	Time	Name of Medication	*Initials	Date <u>mm/dd/yy</u>	Time	Name of Medication	*Initials

\*Signature of Designated Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Designated Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Designated Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Designated Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

Nurse's Medication Comments Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.