Medication Administration Authorization and Log

Child's Name: _____

Name of Medication: _____

For Treatment of: _____

Method of Administration: _____
(Orally, topically, etc.)

Frequency / Times:_____ Amount / Dosage: _____

Date Beginning: _____

Date Ending: _____

I Authorize _____ to
Administer the Above Named Medication.

_____
Parent / Guardian Signature Printed Name Relationship Date

*Please note that all medication must be in its original container!

Date	Time	Medication Name	Amount	Administered By