Kehoe-France Northshore

"As Needed" Medication Authorization Form

ALL MEDICATION MUST BE IN ORIGINAL PACKAGING

Child's Name: _____

Child's Teacher_____

Medication: _____

Dosage: _____

Administered: Orally Topically Other: _____

Side Effects/Anticipated Reactions:

_____

_____

Special Instructions/Circumstances for administering "as needed" medication:

_____

_____

_____

_____

Parent Signature and Date: _____

If all information is not filled in completely, medication will not be administered*

ADMINISTRATION DOCUMENTATION

	Date Given	Time Given	Dosage	Staff Signature

Medication list must be updated by parent as changes occur or at least every six months*