

BRIGHT FROM THE START
Georgia Department of Early Care and Learning

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: _____

Parent's Signature

Date

For Center Use Only

	<u>DATE</u>	<u>TIME GIVEN</u>	<u>AMOUNT</u>	<u>ANY ADVERSE REACTIONS</u>	<u>ADMINISTERED BY</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

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

