# Medication Authorization Form

I, _____, give authorization for _____

to give my child _____the following medication(s):

| Medicine: | Dosage: | How Often: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____        _____
Parent(s) Signature                                      Date

_____        _____
Provider's Signature                                      Date

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| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____        _____
Parent(s) Signature                                      Date

_____        _____
Provider's Signature                                      Date

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