Community Action Partnership
Head Start/Early Head Start

Medication Authorization

To be completed by physician:

Child Name ______________________________

State reason or condition requiring medication ______________________________

Name of medication ______________________________

Dosage ______________________________

Times to be given ______________________________

If prn medication:

- minimum time between doses __________
- maximum number of doses __________
- criteria for administration __________

Route of administration ______________________________

Duration of administration ______________________________

Possible side effects of medication ______________________________

Possible effects on learning and/or physical functioning ______________________________

Instructions for giving medication ______________________________

Physician Signature ______________________________ Date _____/_____/_____

To be completed by parent:

The undersigned as parent/guardian of the above name child requests permission for and hearby authorizes Community Action Head Start to administer the above name medication during school hours.

I have reviewed the Prescription Medication Procedure and understand the procedure required prior to having Community Action Head Start staff administering medication to my child.

Parent/Guardian Signature ______________________________ Date _____/_____/_____

Reviewed by: __________ **Date** ______________
Initial

Reviewed by: __________ **Date** ______________
Initial