AUTHORIZATION FOR MEDICATION

This form must be filled out completely and accurately for each medication prescribed by your physician or the medication will not be administered to your child. All medications must be in their original pharmacy container.

I hereby authorize Saint Luke's Children's Center to administer the following medication to my child							
(Child's Name)							
Parent's Signature							

A physician must fill out this section, or a written prescription with the same information and a Doctor's original signature must be attached to this form.

Prescription:			
Child's Name			
Medication			
Medication route Dosage			
Time medication is to be given			
Medication should be given from		to	
	(Date)		(Date)
Side effects medication may cause	· · · · · · · · · · · · · · · · · · ·		
Doctor's Signature		Date	

For center use only:

Date	Dosage	Time	Medication	Staff Signature	Witness
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