



## Medication Authorization

### Section A: To be completed by parent/guardian

Medication Authorization for: \_\_\_\_\_  
(child's name)

I authorize Herndon United Methodist Church Preschool to administer the medication as specified in Section B of this form. I further certify that it is medically necessary for this medication to be administered.

\_\_\_\_\_  
(Parent/Guardian Name—Please Print)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date authorized)

### Section B: To be completed by Physician for ALL medications kept and administered for more than 10 days (except diaper cream/ointment) and for all Emergency Epinephrine and Nebulizers. Parent/ guardian may complete for diaper cream/ointment and for medications to be kept and administered on site at HUMC Preschool for 10 days or less (Exception: Emergency Epinephrine and Nebulizers).

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Child's Known allergies:

Name of Medication (Including strength): \_\_\_\_\_ Dosage: \_\_\_\_\_ Route:

Frequency to be administered (include time) OR symptoms that necessitate administration: \_\_\_\_\_

Possible side effects (package insert or pharmacy printout with complete list of possible side effects must be included):  
\_\_\_\_\_

What action should HUMC Preschool take if side effects are noted: \_\_\_contact parent \_\_\_contact prescriber \_\_\_other

Special Instructions (package insert or pharmacy printout must be supplied for complete list of special instructions):  
\_\_\_\_\_

Reason child is taking the medication: \_\_\_\_\_

I certify that it is medically necessary for the medication listed to be administered to the child listed above. **This authorization is effective for one year from date authorized below unless otherwise noted.**

\_\_\_\_\_  
Date Authorization Completed

\_\_\_\_\_  
Printed Prescribers Name for long term medications (longer than 10 days)

\_\_\_\_\_  
Prescribers phone number

\_\_\_\_\_  
Licensed authorized prescriber's signature

### Section C: To be completed by HUMC Preschool

My signature indicates that all information needed to give this medication has been given to HUMC Preschool.

\_\_\_\_\_  
Date Received

\_\_\_\_\_  
Authorized Signature