Medication Authorization Form

(Parent/Guardian fills out this side only)

Student Name	Date of Birth ___________________________________ Age _____________
Start Date	Stop Date
Medication (must be in original container with label)	Dosage Amount
Reason for Medication	Times to Be Given (time of day or when the following symptoms occur; "AS NEEDED" is not enough information)
Possible Side Effects	______Oral ______ Topical ______ Other
Does all information comply with the medication label? _______ YES ________ NO	Requires Refrigeration? _______ YES ________ NO
Special Instructions	

____

Parent/Guardian Signature **Date**

Parent/Guardian Daytime Phone ____

____

Physician Name **Phone**

* **A signed doctor note is required before PCA staff will administer a dosage different than the directions on the original medication label.**
* **A copy of the signed doctor treatment plan is required for the use any emergency medications, such as Epi Pens and inhalers.**

Public Health
Seattle & King County

8/14/2020

Medication Record

(Must be filled out by PCA staff giving the medication)

Student Name

Medication

Date	Time	Dosage Amount	Staff Member Initials	Reason *(if not given)*	Side Effects *(if observed)*

Initials & Signatures of PCA staff giving the medication

________ ________________________________ ________ ________________________________

________ ________________________________ ________ ________________________________