



**AUTHORIZATION FOR MEDICATION**

**Child's Full Name:** \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

**Prescription Number:** \_\_\_\_\_

*\* If any medication is only required once or twice daily, Mill Creek will not administer. A parent can do this at home morning and night. If a morning dose requires food, parents are still required to administer.*

**Amount of Medication to be Given:** \_\_\_\_\_

**Time Medication will be administered is 11:00AM unless it is a breathing treatment. If breathing treatment, please list times:** \_\_\_\_\_

**Dates to be Given:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **THRU** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I hereby authorize Mill Creek Academy to administer the above medicine described. I take full responsibility for any adverse reactions to the above medicine. If the medicine requested to administer is over the counter, without a doctor's approval, Mill Creek has the right to refuse to administer due to over-medicating a child.

\_\_\_\_\_  
**PARENT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**FOR CENTER USE**

	<u>DATE</u>	<u>TIME GIVEN</u>	<u>AMOUNT</u>	<u>ANY ADVERSE REACTIONS</u>	<u>ADMINISTERED BY</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:  
\_\_\_\_\_