NORTH STAR ACADEMY OF LANTANA

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Authorization for Dispensing Medication

PARENT'S AUTHORIZATION

Name of Child:	*Name of Medication:*	*Prescription Number:*
Prescribing Physician:	*Prescribing Physician Phone:*	*Expiration Date:*
Dosage:	*When to Give:*	*Continue Medication Until:* _____ MM/DD/YYYY

NOTE: Medication must be in its original container and labeled with your child's name and the date medication is left at the facility. Medication can only be administered in amounts according to the label directions.

_____

Signature-Parent or Guardian *Date*

Disposition of Left-over Medication: ○ Return to Child's Parent/Guardian ○ Thrown Away

Date _____

CAREGIVER'S RECORD OF ADMINISTERING MEDICATION

CHILD'S NAME	NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	AMOUNT GIVEN	FULL NAME OF CAREGIVER OR EMPLOYEE