



Children's Lighthouse of Woodforest ONGOING MEDICATION AUTHORIZATION FORM

Child's Name: _____

Date: _____

- This form is used for **on-going preventative** or **symptomatic medication** only. It must be updated every six months, or as required.
- I hereby request an employee of Children's Lighthouse to administer the medication(s) named below to my child. I understand that all medications must be in the **original container** and **labeled with the child's name** with **directions to administer the medication**.
- Prescription medication must include the date, child's name, and physician's name.
- Over the counter medication label instructions will be followed; a physician's note may be required.
- Parent/Guardian will be informed if any adverse reactions are noticed.
- *By signing below, I release Children's Lighthouse and its employees from all liability for reactions that my child may suffer from this medication.*

PARENT/GUARDIAN'S AUTHORIZATION:

Name of Medication:			Prescribing Physician:	
Prescription Number:	Expiration Date:	Dosage Amount?	Frequency of Dosage:	Continue Medication until (Date):
Symptoms to look for to determine when to give medication:			Possible adverse reactions to look for after medication administration:	

Signature – Parent/Guardian

Date

Medication Administration			Signature of Children's Lighthouse Staff Member	Adverse Reaction Noticed?	Time Parent/Guardian Notified of Adverse Reaction?
Date	Time	Amount			
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	

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