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	
				Yes/No	