Community Action Partnership
Head Start/Early Head Start

Medication Authorization

To be completed by physician:

Child Name _____

State reason or condition requiring medication _____

Name of medication _____

Dosage _____

Times to be given _____

If prn medication:

- minimum time between doses _____
- maximum number of doses _____
- criteria for administration _____

Route of administration _____

Duration of administration _____

Possible side effects of medication _____

Possible effects on learning and/or physical functioning _____

Instructions for giving medication _____

Physician Signature _____ Date _____/_____/_____

To be completed by parent:

The undersigned as parent/guardian of the above name child requests permission for and hearby authorizes Community Action Head Start to administer the above name medication during school hours.

I have reviewed the Prescription Medication Procedure and understand the procedure required prior to having Community Action Head Start staff administering medication to my child.

Parent/Guardian Signature _____ Date _____/_____/_____

Reviewed by: _____Date_____
Initial

Reviewed by: _____Date_____
Initial