Medication Authorization Form

For Prescription and Non– prescription

VDSS Division of Licensing Programs

Instructions:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for **any long-term medication authorizations** (those lasting longer then days).

Section A: To be completed by parent/guardian

Medication authorization for: _____ _____

(Child's name)

_____has my permission to administer the following medication:

(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____

(Start date) **(End date)**

Parent's or Guardian's Signature _____ Date:_____

Section B: to be completed by child's physician

I, _____certify that it is medically necessary for the medication(s) listed

(Name of Physician)

below to be administered to:_____for a duration that exceeds 10 work days.

(Child's name)

Medication(s):_____

Dosage and Times to be admtered:_____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____

(Start date) **(End date)**

Physician's Signature: _____ **Date**: _____

032-05-0570-05-eng (06/12) Physicians Phone: _____

Due to Religious Exemption Medication Authorization has to be renewed every 6 months