

# 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 than 10 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)

(Physician name)

listed below to be administered to: \_\_\_\_\_ for a duration that exceeds 10 work days.

(Child's name)

Medication(s): \_\_\_\_\_

Dosage and times to be administered: \_\_\_\_\_

Special instructions (if any): \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until: \_\_\_\_\_

(Start date)

(End date)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Phone: \_\_\_\_\_

**This Authorization Form is only valid for one year from date of signature.**