Sunflower Montessori and Day Care
Medication Authorization Form
(A separate authorization is required for each medication)

Child's Name: _____ Room: _____

Medication: _____Dose: _____Time:_____
Frequency: _____ Start Date: _____ End Date: _____
Route of Administration: □ Oral □Topical □Inhaled □ Eye/Ear/Nose □Other_____
Reason for Medication:_____ Possible Side Effects:_____
Clinic Address:_____ Phone:_____

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

I,_____, give permission for Sunflower Montessori and Day Care
<div align="center">Parent Name</div>

to give _____ the above-described Medication.
<div align="center">Child's first and last name</div>

Parent's Signature: _____ **Date:_____**

For Staff to Complete

Give medicine **only** if you can answer **yes** to all questions below.

Is the medication Administration Record Complete?	□Yes	□No
Is the medication in a child-resistant container?	□Yes	□No
Is the Original Label/prescription label on the medication container?	□Yes	□No
Is the Prescription current?	□Yes	□No
Is today the date before the expiration date?	□Yes	□No
Is the child's First and Last name on the container?	□Yes	□No

	Monday		Tuesday	Wednesday	Thursday	Friday
Dose						
Date						
Time						
Teacher Name						
Teacher Signature						

	Monday		Tuesday	Wednesday	Thursday	Friday
Dose						
Date						
Time						
Teacher Name						
Teacher Signature						

Unused Medication return date to parents: _____
<div align="center">Place this form in Child's file when administration of medication is done.</div>