Jewish Educational Alliance
Preschool Savannah

MEDICATION AUTHORIZATION

Child's Name _____ Date _____

Name of Medication _____

Prescription Number _____

Date(s) to be Given _____

Time Medication is to be Given _____

Amount of Medication to be Given _____

How medication is to be stored _____

Reason for medication _____

Physician's Name _____ Phone # _____

_____ _____ _____

Parent/Guardian Signature Date Phone #

For School Use

	Date	Time Given	Amount	Any Adverse Reaction	Administered by
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____

If noticeable adverse reaction to medication was observed, what action was taken? Describe.

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_____

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