

MEDICATION AUTHORIZATION FORM
For Prescription and Non-prescription Medications
Summer@Potomac

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 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

Summer@Potomac has my permission to administer the following medication:

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 medications(s) listed
(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.
(Child's name)

Medications(s): _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until _____
(Start date) *(End date)*

Physician's Signature: _____

Physician's Phone: _____