

## MEDICATION AUTHORIZATION

Completion of this form meets the requirements of HFS 45.06(6)(d)1.a., HFS 46.07(6)(f)1.a. & HFS 55.44(6)(e)1.a., Wis. Adm. Codes.  
**Instructions:** Complete this form before any medication (prescription or over the counter) is administered.  
 Scan a **copy immediately to the Health Team** after parent/guardian signature.  
**Separate authorizations are required for each medication!**

Prog:	Child Name:	DOB:
Health Care Provider Recommendation attached (✓): _____ or Date on prescription label: _____ <i>(not required for OTC topical emollients/barriers (i.e.: Vaseline, Chapstick))</i>		

### MEDICATION

Name of Medication Specifically as on label	Dosage	Route (✓) ___ mouth ___ ear: R L ___ eye: R L ___ skin* ___ other: _____ <i>(no rectal meds)</i>	Time to be Administered Be specific, <u>not</u> "PRN" or "as needed"	Valid Dates of Medication – (not more than 3mo)	
				From	To

*\*note below the location the medication/ointment/cream is to be applied to skin*

Administering Medication – Special Instructions and/or possible side effects.

- 1.
- 2.

I hereby authorize administration of the above medication to my child by staff of the program above.	
SIGNATURE – Parent or Guardian	Date Signed

TO BE COMPLETED BY CENTER PERSONNEL each time a dose of medicine is given. Keep this record confidential in the Yellow Health Action Binder. Log the dates and times medication was administered in the center medical log. Complete bottom line and scan a copy to the forms email when medication is no longer required/authorized.

Date Given	Time Given	Person Giving Medication & any comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*(continue on form 182.2 if necessary)*

182 (08/24)

Meds (circle):    used up/date \_\_\_\_\_    returned to family/date: \_\_\_\_\_    disposed of/date: \_\_\_\_\_