Reach Dane

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.
Forward **yellow copy immediately to PNP** 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: *(not required for OTC topical emollients/barriers (ie: Vaseline, chapstick)*		

MEDICATION

Name of Medication Specifically as on label	**Dosage**	**Route (√)** __ mouth __ ear: R L __ eye: R L __ skin* __ other: _____ *(no rectal meds)*	**Time to be Administered** Be specific, not "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 place white copy in child's file when medication is no longer required / authorized.

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

(continue on other side if necessary)

White – Child File/Site Yellow – PNP/Master File 182 (06/17)

Meds (circle): used up/date_____ returned to family/date: _____ disposed of/date: _____