



Sample

Medication Authorization

To be completed by the parent

I, _____ authorize the administration of _____
(Parent's name) *(Name of medication)*

to _____ *(Child's Name)* _____ *DOB*

Effective until: _____ *Possible side effects:* _____

Condition for which medication has been prescribed: _____

Dosage: _____ *Time of day medication is to be administered:* _____

Specific instructions:

Parent Signature

Date

KANATA RESEARCH PARK

Family Centre

The logo consists of several orange handprints of varying sizes arranged in a cluster, partially overlapping the text 'Family Centre'.