MEDICATION AUTHORIZATION FORM

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

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 AUTHORIZATION (those lasting more than 10 days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

COURTHOUSE ACADEMY _____ has my permission to administer the following medication:
(Name of Child Care Provider)

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 medication(s) listed
(Name of Physician)

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

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

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

Physician's Signature: _____ **Date**: _____

Physicians Phone: _____