Medication Authorization Form

Form adapted from the VDSS approved MAT Written Medication Consent Form

- This form must be completed in English
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Short Term Medication (< 10 days): Parents MUST complete for medication to be administered for 10 days or less
- Long Term Medication (>10 days): The child's health care provider MUST complete for Long-Term medication (any medication exceeding 10 days), Emergency Medication or when dosage directions state "consult a physician."
- Any changes to this authorization will require a new authorization

Child's Name _____ Date of Birth_____

Child's Known Allergies:_____

THE SPRINGS, A MONTESSORI SCHOOL has my permission to administer the following medicine:

Medication Name: _____

Route of Administration (circle one): Oral Inhalants Topical Medicated Patches Eye Ear Auto-Injector

Other:_____ (may require additional training from parent/doctor)

Dosage: _____

Time to be Given (Must be a specific time, e.g., 11:00 am): _____

Emergency Medication: Only emergency medication can be given on an as needed (PRN) basis and (e.g., Epi-pen, Inhalers), requires the Physcian's Authorization below. Specific symptoms necessitating the administration of the medicine must be listed below (Additional care plans may be required):

_____

_____

Possible side effects: _____

Special Instructions: _____

What action should THE SPRINGS take if side effects are noted (circle one):

Contact Parent Contact Prescriber Call 911 (automatic for EPI-PEN administration) Other (describe)_____

This authorization is effective until: _____ (The effective period must not exceed ten work days, unless otherwise prescribed by the child's physician and must be a specific date).

Parent or Guardian's Name (please print)_____

Parent or Guardian's Signature: _____ Date of Authorization: _____

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LONG TERM MEDICATION (LONGER THAN 10 DAYS) —REQUIRES PHYSCIANS AUTHORIZATION

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I certify that, in my opinion, it is medically necessary that the medicine described below be administered to _____

_____ during facility hours and that this medicine may be administered by THE SPRINGS staff.

Medication Name: _____

Dosage and Times to be Given: _____

For PRN medications, the following symptoms require the administration of the abovementioned medication: _____

_____

Additional Instructions _____

Name of Physician (please print): _____ Phone: _____

Physician's Signature: _____ Date: _____

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OFFICE USE ONLY

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Facility Name: THE SPRINGS, A MONTESSORI SCHOOL Facility Telephone Number: 703-941-1411

Authorized child care provider's name (please print)_____

Authorized child care provider's signature _____ Date received from parent:_____

AUTHORIZATION TO DISCONTINUE: Please verify with parent and obtain parent signature.

Date of Discontinuation:_____ Reason for discontinuation_____

I certify that my child no longer needs to receive this medication. _____

(Signature of Parent or Guardian)

ADDITIONAL NOTES:

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