



MISSOURI DEPARTMENT OF HEALTH  
BUREAU OF CHILD CARE SAFETY AND LICENSURE  
**MEDICATION AUTHORIZATION**

**MEDICATION REQUIREMENT**

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

**I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:**

**(PROPER NAME OF MEDICATION)**

<b>CHILD'S FULL NAME</b>	<b>DATE MEDICATION TAKEN FROM</b>	<b>UNTIL</b>
<b>DOSAGE</b>	<b>TIME(S) OF DAY</b>	
<b>NUMBER OF PILLS IN BOTTLE</b>	<b>PARENT INITIAL</b> <b>STAFF INITIAL</b>	
<b>POSSIBLE SIDE EFFECTS</b>		
<b>SIGNATURE OF PARENT(S) OR GUARDIAN</b>		<b>DATE</b>

**RECORD OF ADMINISTRATION**

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME