Texas Tech University Child Development Research Center
AUTHORIZATION TO ADMINISTER MEDICATION

Time period this authorization is valid (not to exceed 6 months): _____

☐ **PRESCRIPTION MEDICATION - name of medication_____**

☐ **NON-PRESCRIPTION MEDICATION (also requires separate authorization from physician)**
name of medication_____

✓I have checked that the following information is on the medication:

- ☐ **CHILD'S FIRST AND LAST NAME**
- ☐ **NAME OF MEDICATION**
- ☐ **DOSAGE INFORMATION**
- ☐ **TIMES TO BE ADMINISTERED**
- ☐ **METHOD TO ADMINISTER**
- ☐ **DATE FILLED**
- ☐ **EXPIRATION DATE**
- ☐ **SAFETY LOCK CLOSURE**

MEDICATION RECEIVED BY: _____

CHILD'S FIRST AND LAST NAME:_____

MEDICATION DIRECTIONS: _____

SIDE EFFECTS: _____

ACTION TO BE TAKEN:_____

PARENT'S SIGNATURE _____ DATE_____

DATE(S)	DOSAGE	TIME	- - Staff Signature - - I verify that I have given the 1) right medicine to the 2) right child in the 3) right dosage at the 4) right time and by the 5) right method

**Medications will be returned to parents or destroyed when expired or no longer needed.