Excellence Learning Pod
Renton, WA · (206) 251-4540 · charrita@excellencelearningpod.org

Medication Authorization Form

Required before any medication (prescription or over-the-counter) is given to your child.

Child

CHILD'S FULL NAME

DATE OF BIRTH

Medication Details

MEDICATION NAME

PRESCRIBING DOCTOR

DOSAGE / AMOUNT

ROUTE (ORAL, TOPICAL, ETC.)

REASON FOR MEDICATION

TIME(S) TO GIVE

START DATE

END DATE

SPECIAL INSTRUCTIONS (WITH FOOD, REFRIGERATE, SIDE EFFECTS TO WATCH FOR, ETC.)

Type of Medication

- ☐ Prescription (must be in original container with pharmacy label)
- ☐ Over-the-counter (must be in original container, labeled with child's name)
- ☐ As-needed / emergency medication (e.g., inhaler, EpiPen) — attach action plan

Parent / Guardian Authorization

I authorize Excellence Learning Pod staff to administer the medication described above to my child as instructed. I confirm the medication is in its original, labeled container. I will notify the provider of any changes.

PARENT / GUARDIAN SIGNATURE

DATE

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Staff Use — Medication Log

DATE	TIME	AMOUNT GIVEN	GIVEN BY (INITIALS)