Medication Authorization Form
For Prescription and Non-prescription Medications
VDSS Division of Licensing Programs Model Form

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 authorizations (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: ____________________________________________

(Child’s name)

____________________________________ 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: __________________________

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