Medication Administration Authorization/Log

Name of Child: _____

Medication Prescribed: _____ for: _____

Administration Method: _____
(Oral, topical, etc.)

Frequency of Administration: _____ Dosage: _____

Beg. Date of Medication: _____ End Date of Medication: _____ ***all medication must be kept in its original containers***

I give permission for GVA personnel to administer the above medication to my child as explained above.

_____ _____ _____ _____
Parent Signature Printed Name Relation to Child Date

Medication Log

Date	Time	Medication	Amount	Given By