



3 -DAY CRITICAL MEDICATION AUTHORIZATION

(These medications are to be used only in case of disaster requiring the child to remain at care past the usual hours)

Child's Name:	Date of Birth/Age:
Name of Medication:	Reason for Medication:
Date:	Date to be replaced/rotated*: Expiration date of medication:
<input type="checkbox"/> Scheduled Times to be given:	Amount to be given:
<input type="checkbox"/> Medication is to be given as needed for the following symptoms:	
Possible Side Effects:	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> yes <input type="checkbox"/> no
Special Instructions:	

* Maximum 6 months - sooner as needed.

Parent/Guardian Signature**

Date

Daytime Phone Number

Physician Signature (required)

Date

Physician Phone Number

****Please be sure to inform program if child's health status/medication changes!**