



# Medication Authorization Form

Please use this side for medications given for NO longer than 10 days, excluding nebulizers.

All medications must be received in the original container and packaging. The package insert or pharmacy print out must be included with complete list of side effects and usage instructions. All boxes, containers, and dispensing tools must be labeled with the child's name. For medication samples, all information provided on a prescription label must still be provided. Tuckaway will dispense medications per Tuckaway's medication policy.

Child's name: \_\_\_\_\_ Medication expiration date: \_\_\_\_\_

Name of medication (exactly as it appears on the container): \_\_\_\_\_

Amount /dosage to be given: \_\_\_\_\_  
(Amount/dosage must match package label and/or insert – doctor's permission required if otherwise)

Specific times to be administered at Tuckaway:  10 am  12 pm  3 pm

PRN medications (given as needed)

Symptoms that will necessitate administration of medication (must be observable, and when possible, measurable): \_\_\_\_\_

Frequency to be administered (if subsequent administrations required): \_\_\_\_\_

Additional instructions (must be written by doctor if different from package) \_\_\_\_\_

insert): \_\_\_\_\_

Start date: \_\_\_\_\_ Date medication should be discontinued: \_\_\_\_\_  
(Not to exceed 10 days)

Request to discontinue medication if before original end date: \_\_\_\_\_  
Date Parent Initials

Parent's name: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Tuckaway Use Only:**

Signature indicates all information needed to give this medication has been received by Tuckaway

Authorized MAT provider name: \_\_\_\_\_ Date received: \_\_\_\_\_

Authorized MAT provider signature: \_\_\_\_\_