



# Medication Authorization Form

## Orange County School Age Child Care Programs

For Prescription and Non-prescription Medications

### Instructions:

- One medication per authorization form.
- **Section A** must be completed by the parent/guardian for ALL medication authorizations
- **Section A and Section B** must be completed for an **long-term medication** authorizations (those lasting longer than 10 working days)

**PLEASE PRINT**

### **SECTION A: To be completed by parent/guardian**

Medication authorization for: \_\_\_\_\_  
(Child's Name)

The **Orange County School Age Child Care (OCSACC) staff** has my permission to administer the following medication:

Medication Name: \_\_\_\_\_

Dosage and Time(s) to be administered: \_\_\_\_\_

Special Instructions (if any): \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until \_\_\_\_\_.  
(Start Date) (End Date)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PRINT**

### **SECTION B: To be completed by child's physician**

I, \_\_\_\_\_ certify that it is medically necessary for the medication  
(Name of Physician)

listed below to be administered to: \_\_\_\_\_ for a duration that exceeds 10 work days.  
(Child's Name)

Medication Name: \_\_\_\_\_

Dosage and Time(s) to be administered: \_\_\_\_\_

Special Instructions (if any): \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until \_\_\_\_\_.  
(Start Date) (End Date)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_