GoldenPath ACADEMY

Medication Authorization Form

For Prescription and Non-prescription Medications

Authorization Information must be completed by the parent/guardian for ALL medication authorizations. Physician's Authorization also must be completed for any long-term (longer than 10 consecutive days) medication authorizations.

Child's **Name**

Child's **Age**

Authorization Information (To be completed by parent/guardian)

GoldenPath Academy has my permission to administer the following medication

Medication name	Route
Dosage	Times to be administered
Special instructions (if any)	
Child's known allergies	

This authorization is effective from _____ to _____

(Start date) (End date)

Signature

Parent/Guardian Date

Physician's Authorization (To be completed by child's physician)

I, _____ certify that it is medically necessary for the medication listed
(Name of physician)

below to be administered to _____ for a duration that exceeds 10 consecutive days.
(Name of child)

Medication name	Route
Dosage	Times to be administered
Special instructions (if any)	
Physician's phone number	Physician's fax number

This authorization is effective from _____ to _____

(Start date) (End date)

Signature

Physician Date

571. 349. 9277
www.goldenpathacademy.com
info@goldenpathacademy.com

21631 Ridgetop Circle
Sterling, VA 20166

GoldenPath Academy Admin Signature

Date

GoldenPath ACADEMY

Log of Medication Administration

Child's **Name**

Name of **Medication**

- Use this form to document all medication administered.
- This form must be kept with the child's wri4en medication consent form.
- Any medication errors (i.e. doses of the medication listed below not given) must be documented on this form and an incident report form.

Medication Administration Log

Date Given (mm/dd/yy)	Time (am/pm)	Dose and Route	"As Needed" Symptoms	"As Needed" Time & Date Parent Notified	Administered by (Sign & Print Name)	Side Effects	Medication Error (Include Reason)	Error Time & Date Parent Notified