Authorization to Administer Medication

Facility: _____ Date: _____

Minor: _____ DOB: _____

Guardian: _____ Email: _____

Phone 1: _____ Phone 2: _____

Address: _____

Doctor: _____ Clinic: _____

Phone: _____ Location: _____

Authorized Medications

Medication	Dosage	Day(s)	Time(s)	Authorized Until

_____ _____

Signature Date