Medication Authorization Form
For Prescription and Non-prescription Medications
VDSS Division of Licensing Programs Model Form

INSTRUCTIONS:
- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

### Section A: To be completed by parent/guardian

Medication authorization for: ____________________________________________

(Child’s name)

__________________________________________ has my permission to administer the following medication:

(Name of Child Care Provider)

Medication name: _____________________________________________________

Dosage and times to be administered: ____________________________________

Special instructions (if any): _____________________________________________

This authorization is effective from: __________________________ until: ____________________

(Start date) (End date)

Parent’s or Guardian’s Signature: ______________________________________ Date: ____________

### Section B: to be completed by child’s physician

I, ____________________________________________ certify that it is medically necessary for the medication(s) listed below to be administered to: __________________________________ for a duration that exceeds 10 work days.

(Child’s name)

Medication(s): _____________________________________________________

Dosage and Times to be administered: ____________________________________

Special instructions (if any): _____________________________________________

This authorization is effective from: __________________________ until: ____________________

(Start date) (End date)

Physician’s Signature: ______________________________________ Date: ____________

Physicians Phone: ____________________________