Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

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
(Name of Physician)

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: _____

Medication Form

Camper's Name _____ Session _____

Please complete this form prior to coming to camp. Bring it with you to check in. If you have multiple medications please put them together in a **zip lock bag** with your child's name on the outside of it.

Prescription Medications

Type of Medication (Name should be the same on the medication container)	Time of Day (Breakfast, Lunch, Dinner, Bedtime, or specific time)	Dosage (mg / 1 tab / ½ tab) This should be the same on the medication container

PRN Medication (taken only as needed)

Type of Medication (Name should be the same on the medication container)	Time of Day (Breakfast, Lunch, Dinner, Bedtime, or specific time)	Dosage (mg / 1 tab / ½ tab) This should be the same on the medication container

Over the Counter Medications (Permission Letter)

I, _____, hereby give permission for Camp Kekoka staff to administer over-the-counter medications to my child if they deem it necessary. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise. These medications may include, but are not limited to:

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Tums
Benadryl	Imodium AD	Claritin
Sudafed PE	Generic Cough Drops	Aloe
Pepto-Bismol	Ex-Lax	

Exceptions (not to be given) _____

Signature _____ Date _____