



Camp Griffin Winter 2014-2015

Medication Authorization Form For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs

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)

Westminster School has my permission to administer the following medication:
(Name of Child Care Provider)

Medication Name: _____

Dosage _____

Time(s) to be administered: _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Parent/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: _____

Dosage and Times to be administered: _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Physician's Signature: _____ Date: _____

Physicians Phone: _____