

Medication Authorization Form

This form authorizes Merritt Academy to administer medication to your child.

- If medication will be administered for 10 working days or less, you do not need a physician's authorization.
- Manufacturer's instructions for application must be followed unless authorized by child's physician.
- If medication will be administered for 11 working days or more, you will need a physician's authorization by signing the form below, sending authorization via fax, or providing written authorization in another format (prescription note, written letter, etc.).

Child's Name:
Date of Birth:
Classroom:
Specific Illness/Allergy:
Medication Name:
Dosage and Times to be Given:
Any Adverse Reactions:
Special Instructions (if any):

Parent Authorization		
Merritt Academy has my permission to administer the medication above.		
_____	_____	_____
(Parent's Signature)	(Printed Name)	(Date)
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 18, 2021 <small>(first day administered) (last day of 2020-21 program)</small> <i style="text-align: right; font-size: small;">Authorization may not exceed the last day of the 2020-21 program.</i>		
(Note: If this authorization exceeds 10 working days, your child's physician must provide additional authorization)		

Physician Authorization (only if longer than 10 days)		
I certify that, in my opinion, it is medically necessary that the medication and dosage described above be administered to the child listed above during the hours of operation at Merritt Academy.		
_____	_____	_____
(Physician's Signature)	(Printed Name)	(Date)
This medication is effective from: _____ and until _____ or <input type="checkbox"/> August 18, 2021 <small>(first day administered) (last day of 2020-21 program)</small> <i style="text-align: right; font-size: small;">Authorization may not exceed the last day of the 2020-21 program.</i>		

FOR MERRITT ACADEMY OFFICE USE ONLY		
Date Received: _____	Office Approval: _____	Medication Expiration Date: _____
Refill Date: _____	Office Approval: _____	Medication Expiration Date: _____