



# Alpha Preparatory Academy Medication Authorization Form

<b>Child's Full Name:</b>	
<b>Name of Medication:</b>	
<b>Prescription Number:</b>	
<b>Time Medication is to be Given:</b>	<b>Staff Check One:</b> / ___ / 11:00 am / ___ / 3:00 pm
<b>Amount of Medication to be given:</b>	
<b>Date (s) to be given:</b>	

**Parent Signature or Guardian:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

## For Center Use

DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	ADMINISTERED BY:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

If noticeable adverse reaction to medication what action was taken? Describe

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