

Medication Authorization and Log

Name of Parent/Guardian: _____

(Please Print)

I, the undersigned parent or guardian, give permission for employees of United Cerebral Palsy of Greater Dane County to administer the below medication to _____ according to the stated directions below and on the bottle. I have read UCP's policy for Medication Administration Policy and understand and agree that United Cerebral Palsy and its employees will not be held responsible for any ill effects which might occur in connection with the administration of the medication as defined below.

Signature of Parent/Guardian _____ Date: _____

To Be Completed By Parent/Guardian:

1. Medication and Dosage: _____
Frequency and Times: _____
Reason for Medication: _____
Special Instructions: _____

Side effects that might occur: _____

2. Medication and Dosage: _____
Frequency and Times: _____
Reason for Medication: _____
Special Instructions: _____

Side effects that might occur: _____

3. Medication and Dosage: _____
Frequency and Times: _____
Reason for Medication: _____
Special Instructions: _____

Side effects that might occur: _____

4. Medication and Dosage: _____
Frequency and Times: _____
Reason for Medication: _____
Special Instructions: _____

Side effects that might occur: _____

5. Medication and Dosage: _____
Frequency and Times: _____
Reason for Medication: _____
Special Instructions: _____

Side effects that might occur: _____
