Medication Authorization and Log

Name of Parent/Guardian: ___________________________________________

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: ______________________________________________________________________

Please see reverse side
**Date Medication was Administered:** _______________________________________________

(A separate form should be completed for each day medication was administered)

**To Be Completed By UCP Employee:**

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<thead>
<tr>
<th>Time</th>
<th>Medication Name</th>
<th>Dosage</th>
<th>Comments or Notes</th>
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Signature of UCP Employee: ___________________________________ Date: ______________________

Guardian Reviewer: _________________________________________ Date: ______________________

(Signature of parent/guardian)

Upon completion, the form (front and back) should be emailed to respite@ucpdane.org within 24 hours of administering medication.

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Please note:

- A separate form must be used for each day medication is administered.
- Only medication listed on the reverse side can be administered, this includes over the counter medications.
- UCP employees will not administer any medication without written authorization, specific instructions or if the medication is not in its original packaging unless they have a UCP supervisor’s approval.

Please review UCP’s Medication Authorization Policy for more details.

Please see reverse side