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:

Time:	Medication Name:	Dosage:	Comments or Notes:

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.

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 it's original packaging unless they have a UCP supervisor's approval.

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

Please see reverse side