Medication Authorization Form

For prescription and non-prescription medications

HIMCHARI MARTIAL ARTS

Instructions:
Section A and **Section B** must be completed for all medications.
Section A, **Section B**, and **Section C** (on reverse side) must be completed for prescription medications.

Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription medication must be in the original container with the label intact.
Special instructions must not conflict with label.

Section A – To be completed by parent or guardian

Child Name	Date of Birth
Medication Name	
Purpose of Medication	
Dosage	

Please Check One and Complete

	Times Administered
	Conditions Administered Under

Special Instructions

Authorization Start Date	Authorization End Date

Section B – To be completed by parent or guardian

I hereby give permission for my child (named above) to receive the above listed medication, according to the listed directions and cautions, administered by or under the super vision of Himchari Martial Arts' agents. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I agree to give all possible doses to my child myself, either before or after my child attends the program at Himchari Martial Arts. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine if necessary. I authorize Himchari Martial Arts' agents to contact the pharmacist or healthcare provider for more information about this drug or regarding my child's health, if necessary.

Parent / Guardian Name	Date
Signature	

Medication Authorization Form

For prescription medication

Section C – To be completed by the prescribing physician

Child Name	Date of Birth
Medication Name	
Purpose of Medication	
Dosage	

Please Check One and Complete

	Times Administered
	Conditions Administered Under

Special Instructions

Authorization Start Date	Authorization End Date

I certify that it is medically necessary for the medication listed above to be administered to the child listed on this form for a duration that exceeds 10 work days.

Physician Name	Date
Signature	
Contact Number	