Medication Authorization Form
For Prescription and Non-prescription Medications
VDSS Division of Licensing Programs

INSTRUCTIONS:
• Section A must be completed by the parent/guardian for ALL medication authorizations.
• Section A and Section B must be completed for any long-term medication authorizations (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: ____________________________________________________________
(Child’s name)

Mountaintop Montessori __________________ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _________________________________________________________________

Dosage and times to be administered: _______________________________________________

Special instructions (if any): _______________________________________________________

This authorization is effective from: ___________________________ until: __________________
(Start date) (End date)

Parent’s or Guardian’s Signature: ______________________________________ Date: __________

Section B: to be completed by child’s physician

I, ___________________________ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to: _______________________________________________________
(Child’s name) for a duration that exceeds 10 work days.

Medication(s): _________________________________________________________________

Dosage and Times to be administered: _____________________________________________

Special instructions (if any): ______________________________________________________

This authorization is effective from: ___________________________ until: __________________
(Start date) (End date)

Physician’s Signature: ______________________ Date: __________________

032-05-0570-05-eng (06/12) Physicians Phone: __________________________