Medical Authorization Release Form

Child's Name: _____

- To be completed by Parent/Guardian for all scheduled medications
- One medication and treatment per form
- Parent/Guardian to review at end of treatment
- This record will be kept in Child's file

Name of Medication: _____

Dosage: _____

Description: [ ] Tablet [ ] Capsule [ ] Liquid [ ] Spray/Inhalant [ ] Other

Start Date: _____ End Date: _____

Storage Instructions: _____

Administration Instructions:

_____

_____

Stop Medication/Treatment if:

_____

_____

I release Bethany Chapel and its staff from any liability, however cause, arising out of administering, or failure to administer, the medication provided herein.

Parent Signature: _____

Parent Name: _____ Date: _____