Public Health
Seattle & King County

3 –DAY CRITICAL MEDICATION AUTHORIZATION FORM

(These medications are to be used only in case of disaster requiring the child to remain in care past usual hours)

Child's Name:	**Date of Birth/Age:**
Name of Medication:	**Reason for Medication:**
Date to be replaced/rotated*: ____/____/____	**Expiration date of medication:** ____/____/____
☐ **Scheduled times to be given (please list times below):**	☐ **To be given as needed for the following symptoms (please list symptoms below):**
Dose (Amount to be given):	
Possible Side Effects:	**Route:** ☐ **Oral** ☐ **Topical** ☐ **Other**
☐ **Above information consistent with label?**	**Requires Refrigeration:** ☐ **Yes** ☐ **No**
Special Instructions:	

* Maximum 6 months – sooner as needed.

Parent/Guardian: Please be sure to inform child care program if child's health status/medication changes

_____ _(____)_____

Health Care Provider Name (please print) **Phone Number**

_____ _____

Health Care Provider Signature **Date**

_____ _(____)_____

Parent/Guardian Name** (please print) **Phone Number**

_____ _____

Parent/Guardian Signature **Date**