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 at care past the usual hours)*

| | |
|---|---|
| **Child's Name:** | **Date of Birth/Age:** |
| **Name of Medication:** | **Reason for Medication:** |
| **Start Date:** | **Stop Date:** |
| ☐ **Scheduled Times to be given:** | **Amount to be given:** |
| | |
| | |
| | |
| | |
| ☐ **Medication is to be given as needed for the following symptoms:** | |
| **Possible Side Effects:** | ☐ **Oral** ☐ **Topical** ☐ **Other** |
| ☐ **Above information consistent with label?** | **Requires Refrigeration:** ☐ **yes** ☐ **no** |
| **Special Instructions:** | |

_____ _____

**Parent/Guardian Signature** **Date**

_____

**Daytime Phone Number**

_____ _____

**Physician Signature (required)** **Date**

_____

**Physician Phone Number**