Public Health
Seattle & King County

3 -DAY CRITICAL MEDICATION AUTHORIZATION

(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:
Date:	Date to be replaced/rotated*: Expiration date of medication:
☐ 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:	

* Maximum 6 months - sooner as needed.

_____ _____

Parent/Guardian Signature** Date

_____

Daytime Phone Number

_____ _____

Physician Signature (required) Date

_____

Physician Phone Number

****Please be sure to inform program if child's health status/medication changes!**