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 (list symptoms below):**
Dose (Amount to be given):	
Possible Side Effects:	**Route:** ☐ **Oral** ☐ **Topical** ☐ **Other**
	Requires Refrigeration: ☐ **Yes** ☐ **No**
Above information consistent with label? ☐ **Yes** ☐ **No**	
Special Instructions:	

* Maximum 6 months – sooner as needed.

Parent/Guardian: Please 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**