EFM RESPITE CARE
AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION ADMINISTRATION

Child's Name:	Date of Birth:
Allergies to Medications:	

CURRENT MEDICATION REGIMENT

MEDICATION	PURPOSE	DOSAGE	FREQUENCY/TIME	DURATION	POSSIBLE SIDE EFFECTS
1.					
2.					
3.					
4.					

I hereby authorize, my authorized respite care provider(s) to administer the above medications, to my child Listed above. I further agree to indemnify and hold harmless this provider, his/her agents, and servants against all claims of any acts performed under this authority.

_____ _____ _____

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

MEDICAL PROVIDER

Please review and check each statement before signing below:

[ ] I have reviewed the above medication administration request by the parent /guardian of the child.

[ ] The medication is available over-the-counter and can be given as recommended on the label.

[ ] For medication that does not provide the exact dosage on the label, I have recommended the above based on the child's age and weigh and concur with the above regiment.

Medical Provider Signature: _____ **Date:** _____

Printed Name /Stamp

Required if hand signing