



**Fun and Friends Child Development Center**  
1609 Great Falls St., McLean, VA 22101

**EXTENDED MEDICATION AUTHORIZATION**  
**Prescription and non-prescription**  
**Must be renewed every 3 month**

I certify that, in my opinion, it is medically necessary that the medication described below be administered for a period longer than 10 days to \_\_\_\_\_ during center hours and that Center Staff may administer this medication.

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

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Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Drug Name and Prescription Number: \_\_\_\_\_

Dosage to be given: \_\_\_\_\_

Times to be given: \_\_\_\_\_

**(Must state exact hour, minute, not after lunch or after nap)**

Special Instructions (if any): \_\_\_\_\_

This authorization is effective until: \_\_\_\_\_

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, request that center staff administer the medication above to my child during center hours. I also agree to furnish the medication in the original container with the label intact.

\_\_\_\_\_  
**Signature of Parent/ Guardian**

\_\_\_\_\_  
**Date**