



**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

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