STATE OF WISCONSIN
DEPARTMENT OF WORKFORCE DEVELOPMENT
Division of Workforce Solutions

Authorization to Administer Medication

Use of form: This form is **mandatory** for certified providers to comply with DWD 55.08(4)(f) and 55.09(5)(c), Wisconsin Administrative Code. Failure to comply may result in issuance of a non-compliance statement. Personally identifiable information gathered on this form will be used only to verify compliance with the certification rules.

Instructions: This form shall be completed and signed by the parent or guardian before any medication is administered. Place form in child's file when medication is no longer required/authorized.

Provider Name

Child Name	Date of Birth (mm, dd, yyyy)

MEDICATION

Medication Name	Dosage	Time of Day Administered	Medication Time Period (Dates) To	From
		☐ AM ☐ PM		
		☐ AM ☐ PM		
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Administering Medication - Special Instructions:

AUTHORIZATION

I hereby authorize administration of the above medication(s) to my child by the childcare provider listed above.

SIGNATURE - Parent or Guardian	Date Signed