Medication Authorization – Chronic Use (Up to 12 Months)

(OAR 414-360-0230(1)(c) & 414-360-1030)

Child's Name: _____

Medication Name: _____

Reason for Medication: _____

Dosage: _____
When to Administer (specific circumstances or symptoms):

How to Give Medication: _____

Refrigeration Required? ☐ Yes ☐ No

Authorization:
I authorize Chickadee Ridge Early Learning Center staff to administer the above medication to my child as needed for the chronic condition described. This authorization is valid for up to 12 months from the date signed, unless revoked in writing sooner.

Parent/Guardian Name: _____
Parent/Guardian Signature: _____
Date: _____