CORNERSTONE
AUTISM CENTER

AUTHORIZATION FOR MEDICATION ADMINISTRATION

I hereby authorize staff members at Cornerstone Autism Center to administer the following medication to my child, _____.
I further agree to indemnify and hold harmless this facility/center, their agents, and servants against all claims as a result of any and all acts performed under this authority.

Parent/Guardian Name _____

Telephone _____

My child's health care provider is _____

Telephone _____

My child's condition is _____

Name of medication _____

Purpose of medication is _____

Time of administration _____

Method of administration _____

Possible side effects _____

In case of emergency, contact _____

Telephone _____

Parent/Guardian signature _____

Today's Date _____