Pediatric Weight-Based Dosage Authorization

Date: [Insert Date]

Child's Full Name: [Insert Child's Name]

Date of Birth: [Insert DOB]

Current Weight: [Insert Weight] [lbs/kg] as of [Insert Date Weight Taken]

Medical Provider Authorization

To the Administration of [Insert Childcare Facility Name],

I, the undersigned medical professional, authorize the administration of the following medication(s) based on the child's current weight:

Medication Name	Indication (e.g., Fever/Pain)	Dosage (by Weight)	Route (e.g., Oral)	Frequency
[Insert Medication]	[Insert Reason]	[Insert mg or ml]	[Insert Route]	Every [X] hours

Special Instructions/Precautions: [Insert any allergies or side effects to watch for]

Physician/Provider Name: [Insert Name]

Clinic Name: [Insert Clinic Name]

Phone Number: [Insert Phone Number]

Provider Signature: ____________________________

Parent/Guardian Consent

I give permission for [Insert Childcare Facility Name] staff to administer the medication listed above to my child according to the weight-based dosage provided by our medical provider. I agree to notify the facility immediately if there is a change in my child's weight or medical status.

Parent/Guardian Name: [Insert Name]

Phone Number: [Insert Phone Number]

Parent/Guardian Signature: ____________________________

Date: [Insert Date]