

Kids Academy Medication Authorization Form

Center: Kids Academy

Name of Child: _____ Date of Birth: _____ Room: _____

TO BE COMPLETED BY PHYSICIAN:

Name of PRESCRIBED Medication: _____

Prescription/RX#: _____

Reason for Medication:

Frequency/Route (times per day): _____

Specific Instructions (include precautions, side effects/reactions and/or any intervention):

Please indicate how long this prescribed medicine should be administered during program hours: _____

Physician Signature: _____ Date: _____

Address: _____ City/State: _____

Telephone: _____

Parent Authorization:

I authorize Kids Academy Staff to administer the above medication to my child.

Parent Signature

Date