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