

KinderStop On-Site Medication Authorization Form

Name of Child: _____ D.O.B.: _____ Today's Date _____

Name of Medication: _____

Reason for Medication: _____

Dose: _____ Time/Frequency _____

Route: Oral Topical Inhaled Injection Other

Additional Instructions/Comments: _____

Known Side Effects: _____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider: _____

Phone Number: _____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received: _____

Staff Member Signature: _____

Staff Member Signature: _____

I authorize KinderStop On-Site personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian Printed Name: _____ Date Signed: _____

Parent/Guardian Signature: _____