Prescription Medication Authorization Form

Legal Last Name:_________________________ Legal First Name:_______________________

Date of Birth:____________________________ Studio Level:__________________________

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To Be Completed by Licensed Healthcare Provider with NO Abbreviations

Reason(s) for Medication:____

List of Tiggers:____

Name of Medication:____

Start Date of Medication:__________________ End Date of Medication:______________

Method of Delivery: ______________________ Dosage:________________________________

Administration:

☐ Daily Time:____

☐ As Needed: (Explain signs or symptoms that would indicate medication needs to be given.)

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Interval for repeating dosage:____

Medication cannot be repeated more than:_______________________________________

Side effects or additional comments:____

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Name of Healthcare Provider:_____________________________ Phone:_______________

Signature of Provider:_______________________________________ Date:________________

Name of Parent/Guardian:________________________________ Phone:_______________

Signature of Parent/Guardian:_____________________________ Date:________________