KINGDOM KIDS ACADEMY

PERFORMING & VISUAL ARTS

CHILDCARE MEDICATION AUTHORIZATION FORM

TODAYS DATE _____

NAME OF CHILD: _____D.O.B._____

NAME OF MEDICATION : _____

REASON FOR MEDICATION: _____

DOSE: _____ TIME/FREQUENCY: _____

ROUTE: ORAL _____ TOPICAL _____INHALED _____ INJECTION _____ OTHER ____

DATE TO START _____ DATE TO STOP _____ EXPIRATION _____

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 _____

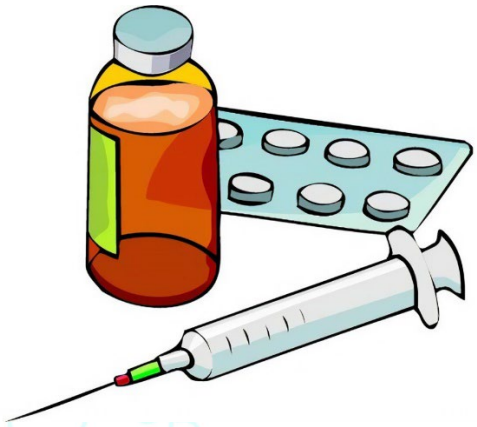
STAFF MEMBER SIGNATURE _____

I AUTHORIZE __KINGDOM KIDS ACADEMY __ PERSONNEL TO ADMINISTER THE MEDICATION NAMED ABOVE TO MY CHIKLD IN THE MANNER AS STATED. I RELEASE ANY LIABILITY IN RELATION TO THE ADMINISTRATION OF THIS MEDICATION. I ALSO ACKNOWLEDGE THAT I, THE PARENT HAVE GIVEN THE FIRST DOSE OF THIS MEDICATION WITHOUT ANTY ALLERGIC OR UNEXPECTED REACTIONS.

PARENT PRINTED NAME _____ DATE _____

PARENT SIGNATURE _____

RETURN OR DISPOSAL OF MEDICATION



RETURN DATE _____ **DISPOSAL DATE** _____

PARENT SIGNATURE _____

STAFF SIGNATURE _____

WITNESSES TO DISPOSAL _____

_____

_____

DATE _____