MEDICATION AUTHORIZATION FORM

Name: _____ Age: _____

Date	*Name of Medication*	*Reason for medication*	*Dosage*	*Time to be administered*	*Administered by*	*Actual time administered*

The Kidoodle Learning Center Staff is authorized to administer medication in accordance with a doctor's or parent signature

Parent/guardian signature _____

Adverse reactions: _____

_____

_____

_____

_____