



**Prescriber's Authorization for Administration of Medication at Kids of the Kingdom Program**

To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Child \_\_\_\_\_ Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

Time to be taken during Kids of the Kingdom 2007 hours, (8:30 AM – 4:30 PM) \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any) \_\_\_\_\_

Other recommendations \_\_\_\_\_

Name of Licensed Prescriber and title (please print) \_\_\_\_\_

Prescriber's

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**This Prescriber's Authorization form and Medicine Administration form need be returned only when and if your child requires medication to be administered by us.**