Physician's Medication Administration Permission Form

Patient Name: _____ Date of Birth: _____

Allergies: _____

PLEASE LIST EACH MEDICATION SEPARATELY

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____ How Often? _____

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____ How Often? _____

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____ How Often? _____

Physician's Name(Printed): _____ Tel.: _____

Physician's Signature: _____ Date: _____