Able-
SERVICES

Part of the Leg Up Farm Family

HEALTHCARE PROFESSIONAL AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

Participant Name: _____ Date of Birth: _____

Name of Medication	**Condition/Symptoms Treated by Medication**	**Dosage** (must include strength & amount)	**Route of Ingestion**	**Time of Administration** (must be an actual time or PRN, not acceptable to list AM, PM, lunch, etc)

Special Instructions: _____

_____

Healthcare Professional Printed Name: _____

Practice Name: _____ Phone: _____

Address: _____

_____

_____ _____

Healthcare Professional's Signature Date