

**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

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