



SOARING SKILLS LLC

Medication Authorization Form

919 Hoeschler Drive, Sparta, WI 54656 | 608-855-4004 | kmoran@soaringskills.com

1. CLIENT INFORMATION

CLIENT FULL NAME	DATE OF BIRTH	PROGRAM (CCS / CLTS)
PARENT / GUARDIAN	PRIMARY PHONE	EMERGENCY PHONE

2. MEDICATION INFORMATION

MEDICATION NAME		REASON / DIAGNOSIS		
DOSE	ROUTE	TIME(S) TO BE GIVEN DURING SERVICES	START DATE	END DATE

☐ Prescription ☐ Over the counter ☐ Requires refrigeration

SPECIAL INSTRUCTIONS, SIDE EFFECTS TO MONITOR, OR PRECAUTIONS

Note: Medication must be provided in the original supplied bubble/blister/strip pack, and each dose must remain sealed and intact in the original packaging. Opened, damaged, altered, or partially used bubble/blister/strip packs will not be accepted.

3. PARENT / GUARDIAN AUTHORIZATION

I request that the above medication be administered to my child during Soaring Skills services as directed. I understand the medication must be supplied in the original labeled container, and I authorize trained Soaring Skills staff to administer it according to this form and Soaring Skills policy.

Parent/Guardian signature

Printed name

Date

Email

Alternate contact

Phone



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Have the prescribing provider complete this section when required by Soaring Skills policy or state law.

4. LICENSED PROVIDER AUTHORIZATION

CLIENT NAME		MEDICATION		
PURPOSE OF MEDICATION	MEDICATION ROUTE	FREQUENCY / EXACT TIME	START DATE	END DATE
PURPOSE OR DIAGNOSIS				
SPECIAL INSTRUCTIONS, POSSIBLE SIDE EFFECTS, CONTRAINDICATIONS, OR ACTION TO TAKE FOR MISSED DOSE				
LICENSED PROVIDER NAME	CLINIC / PRACTICE		PHONE	

Provider signature

Fax

Date

5. SOARING SKILLS USE ONLY

MEDICATION RECEIVED BY	DATE RECEIVED	QUANTITY RECEIVED	EXPIRATION DATE
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Medication count verified: ☐ Yes ☐ No

☐ Stored in locked medication cabinet

STAFF NOTES

Staff signature

Printed name

Date