Reynolda Preschool

Parent Request and Physician's Authorization for Administration of Medication in School 2018-2019

Student Name_____

Date of birth _____

Parent/Guardian Name_____

- I give permission for my child to receive the medication listed below at school. This medication has been prescribed by a licensed health care provider.
- I understand that Reynolda Preschool discourages the administration of medications at school unless it is necessary for the health of the student. This request is being made in view of the health needs of my child and the recommendation of my child's healthcare provider to administer this medication at school.
- I agree to place and the send the medication to school in an appropriately labeled container which has written on it: my child's name, the name of the medication, the unit of dosage to be given, the number of dosage units, the time the medication is to be given, and how it is to be administered.
- I also agree that Reynolda Preschool and its employees and agents are not liable for an injury arising from the administration of the medication in accordance with the health care provider's prescription or instructions.

Medication _____ Dosage:_____ Time of admin_____

Significant information about the medication

_____

_____

_____

Emergency Instructions:

_____

_____

_____

Physician Signature: _____ Date_____

Parent Signature: _____ Date_____

Phone #: _____

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