

**Reynolda Preschool
Parent Request and Physician's Authorization
for Administration of Medication in School
2019-2020**

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 _____

Parent Phone #: _____