

# HARRISON UMC PRESCHOOL

## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION TO STUDENTS

STUDENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

It is necessary that this student receive medication during school hours.

Purpose of this medication: \_\_\_\_\_

Strength, Concentration, Form: \_\_\_\_\_

Directions for administration (when to give, relation to meals) \_\_\_\_\_

\_\_\_\_\_

How much \_\_\_\_\_ How long \_\_\_\_\_

Do not give if (specific contraindications): \_\_\_\_\_

\_\_\_\_\_

Stop medication and contact physician if following side effects develop: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\*\*\*\*\*

### PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. On behalf of my child and on behalf of the child's parents and/or legal guardians, I absolve **HARRISON UNITED METHODIST PRESCHOOL** and their agents and employees from any and all liability whatsoever that may result from my child taking this prescribed medication. I understand that I am responsible for providing my child's medication to the school.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date