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