LANCASTER PRESCHOOL

Permission to Administer Medication / Allergy Information

Name of Student: _____

Medical Condition/Allergy Information: _____

This Portion to be completed by Physician

Name of Medication to be administered: _____

Criteria for giving the medication: _____

_____

Amount and frequency of dosage: _____

Expiration of prescription: _____

Describe how the medication is to be administered: _____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____Phone:_____

This Portion to be Completed by the Child's Parent/Guardian

Authorization must be provided for staff to administer prescription or over-the-counter medication to a child, when needed, as per the doctor's orders as listed above, for chronic medical conditions and for allergic reactions. Item must be provided in its original container and labeled clearly with the child's name.

I, _____(parent name) request Lancaster Preschool personnel to

administer the medication above to _____ (child name).

Parent/Guardian Signature: _____ Date: _____

Date Received: _____ Staff Initials: _____