LANCASTER PRESCHOOL

369 Air Harbor Road

Greensboro, NC 27455

Permission to Administer Medication for Chronic Medical Conditions and Allergic Reactions

Name of Student: _____

Medical Condition: _____

This Portion to be completed by Physician

Name of Medication to be administered: _____

Criteria for giving the medication:

_____

Amount and frequency of dosage:

_____

Describe how the medication is to be administered:

_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____Phone:_____

_____

This Portion to be Completed by 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.

PARENT PERMISSION:

I request Lancaster Preschool personnel to administer the above medication to:

(Student's Name)

_____Prescription Expiration Date: _____

PARENT/GUARDIAN SIGNATURE

This Portion to be Completed by the Teacher/Staff

Date Received: _____ Next Due Date: _____ Staff Initials: _____