LANCASTER PRESCHOOL

Medical Information and Medication Authorization

Name of Student _____ DOB _____

My child named above should receive medication as described below as prescribed by his/her physician. I understand this medication should be provided to Lancaster Preschool in the original and labeled container from the pharmacy (prescription medication and OTC), including any necessary refills. I understand that my child's teacher, or an Office Administrator, will administer the medication to my child as directed below. I understand that this form is good for one year from the date signed by my child's physician below and a new form must be completed annually.

Parent/Guardian Signature _____ Date: _____

This Portion to be completed by Physician

I request that the patient named above receive the medication(s) listed below as described below for

the following condition(s): _____

_____

_____.

Medication Name (Prescription and OTC)	Dosage	Frequency/Time of Day	Route of Administration

Possible side effects or adverse reactions (if applicable): _____

_____

Physician's Name: _____Phone:_____

Physician Address: _____

Physician's Signature: _____ Date: _____

Date Received: _____ Staff Initials: _____

06/04/2026