

Time to Shine Preschool, LLC
Authorization for administration of medication

Medication Type (Please circle one):

Prescription

Non-prescription

Topical ointment

I hereby authorize Time to Shine Preschool, LLC to administer the following medications to my child:

Child's Name: _____

- Prescription medications must be in original packaging with clear instructions.
- Non-prescription medication to be used for more than three consecutive days requires a written order from the parent.
- Duration of non-prescription topical ointments' (authorized for use for children) authorization cannot exceed 90 days.
- Duration of as needed medications require a written order from the child's parent and cannot exceed 90 days.

I further agree to indemnify and hold harmless Time to Shine Preschool, LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Medication: _____

Administrative Route: _____

Reason for Medication: _____

Medication Storage: _____

Side Effects: _____

Dosage: _____

Times of Administration: _____

Start Date: _____ End Date: _____

Physician's Name: _____ Physician's Number: _____

Parent/Guardian Signature: _____

