

PRESCHOOL Medical Authorization Form

Complete and submit with your registration form only if it pertains to your child.

**Preschool staff will not give your child medicine unless you complete and sign this form. You are responsible for updating this form as the child's medical needs change.

CHILD'S NAME		DATE OF BIRTH
Address:		
Medical condition or illness:		
For how long will your child need to take this medication?		
Date dispensed:		
NAME OF MEDICINE (as described on container)	WHEN TO BE GIVEN	DOSAGE:(How much to give)
Special precautions:	Side effects:	
Any other instructions:		
PROCEDURES TO TAKE IN AN EMERGENCY:		

EMERGENCY TELEPHONE NUMBERS: (parent/caregivers or other contacts)

NAME & RELATIONSHIP TO CHILD	TELEPHONE NUMBERS

I understand that I must deliver the above medication personally and accept that this is a service which the school is not obliged to undertake and I hereby waive all rights of action on behalf of ourselves and/or our child of any cause of action that may arise as a result of proceeding with our request for administering medication or a medical procedure. I give permission for my child to be given the above named medication.

Parent/Caregiver: NAME: _____ SIGNATURE: _____

DATE: _____