

PERMISSION FOR THE DISPENSEMENT OF MEDICATION

Date: \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

It is necessary that the above named child receive the following medication during school hours. Please administer as follows:

Name of medication \_\_\_\_\_

Time of administration \_\_\_\_\_

Dosage \_\_\_\_\_

How to be administered \_\_\_\_\_

Reason for medication \_\_\_\_\_

Prescribing physician \_\_\_\_\_

Physician's telephone number \_\_\_\_\_

I understand that I must notify the Preschool immediately if there are any changes in the above arrangements. I also know that all scripts are good for 6 months and will need a renewal to continue the medication here at school.

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Physician's signature