Preschool Medication Authorization Form

Today's Date _____ Child's Teacher _____

My child, _____has been prescribed medication and/or has permission to take non-prescription medicine while at school. He/She will take:

Medicine name:_____

(Strength in mg)_____ (Dosage amount to be given)_____

- □ Daily at_____(Time)
- □ As needed _____ (Reason)
- □ Other_____
  _____
  _____

DAILY = valid for one Monday-Friday week. **AS NEEDED** = valid for 6 months.

I hereby authorize the following personnel to administer this medication to my child. (Please check)

_____Preschool Nurse (between 9:00 am and 2:30 pm) _____Preschool Office Personnel

Any **PRESCRIPTION medication** to be administered during school hours must be in the ORIGINAL LABELED CONTAINER AS DISPENSED BY THE PHARMACIST or it **cannot** be given at school.

ALL **non-prescription medication** must be brought in a NEW AND UNOPENED container. If your child **is under the age of 2** then a physician's medication order will also be required for any over-the-counter and prescription medication to be given at school. This can be faxed, emailed, or dropped off. Our fax # is 225-293-9447, email is nurse@pbcbr.org.

If we have any questions, we will contact you. We also call before giving an "as-needed" medication.

Parent's Signature_____

Parent Contacted (Name)	Date Given	Time Given	Dosage	Staff Signature