

Preschool Emergency Medication Authorization Form

Today's Date: _____ Child's Grade/Teacher: _____

My child, _____ has been prescribed medication and/or has permission to take non-prescription medication during school hours.

He/She will take:

Medication: _____

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

As needed (reason): _____ (valid for 6 months OR sooner)

I hereby authorize the following personnel to administer this medication to my child.

_____ School Nurse _____ School Staff (office/teacher)

All **prescription** medication that needs to be administered during school hours must be in its **original labeled container as dispensed by the pharmacist** or it **cannot** be administered at school.

All **non-prescription** (over the counter) medication must be brought in a **new and unopened** container, or it **cannot** be administered at school.

*I release the school, school board members, officers, and personnel and will hold Parkview Baptist School and such persons harmless from any damages, liability, or loss resulting from compliance or attempted compliance in good faith with this request and authorization. I recognize that I am primarily responsible for administering medications to my child and realize that Parkview Baptist School is not assuming responsibility for my child's care but is acting on my behalf when I am unable to personally administer a medication. *

Signature of Parent/Guardian: _____ Contact Number: _____

Administration Documentation

Date	Time	Dosage	Symptoms Observed	Actions Taken	Staff Signature	Parent Contact Time	Observation Completed By

****Shall be updated by parent as changes occur or at least every 6 months****

Signature of Staff: _____ **Date:** _____