PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Children's Choice Montessori School

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Children's Choice Montessori School to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at Children's Choice.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Portland Street Child Development Center

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Portland Street to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at Portland Street.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Pearl Buck Center

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Pearl Buck Center to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at Pearl Buck.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

First Place Family Center

Child's Name (please print): _____

To be completed by parent:

I hereby authorize First Place Family Center to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at First Place.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Lane Community College Child Development Center

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Lane Community College Child Development Center to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at LCC.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Unity School Inc.

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Unity School Inc. to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at Unity.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File

PARENT PERMISSION FOR PRESCRIPTION MEDICATION ADMINISTRATION

Parkside Community Preschool

Child's Name (please print): _____

To be completed by parent:

I hereby authorize Parkside Community Preschool to assist my child to take the following medications at school.

A separate form must be completed for every medication a child is taking while at Parkside.

Reason for medication: _____

Name of medication/Time to be given:_____

Possible side effects to watch for: _____

Name of prescribing physician: _____

Parent/Guardian Signature: _____

MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND HAVE THE PRESCRIPTION LABEL

Prescription label must include: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

To be completed by staff:

Special Instructions: _____

Verification of medication and dosage:

Staff Name (print): _____ Staff Signature: _____

Date	Time	Dosage	Note any side effects observed	Signature of person administering medication

The medication and dosage must be documented every time it is given.

WHITE: Parent Copy PINK: Office YELLOW: School File