ALL SAINTS EPISCOPAL PRESCHOOL
MEDICATION AUTHORIZATION FORM

(Note: ONLY fill out this form if your child needs to take medication at school)

TO BE COMPLETED BY PARENTS:

Child's name _____

Medication name _____

Dosage and times to be administered

_____

Authorization effective until (give date) _____

I authorize personnel at All Saints Episcopal Preschool to administer this medication to my child.

Parent Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN (for any long-term medications, lasting more than 10 days)

Name of physician _____

Physician's phone number _____

Child's name _____

Medication name _____

Dosage and times to be administered _____

Special instructions _____

Authorization effective until (give date) _____

Physician's Signature _____ Date _____

TO BE COMPLETED BY ALL SAINTS PRESCHOOL PERSONNEL (for devices such as EpiPen, Jr. and inhalers)

The following preschool staff have been trained to administer this medication:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name of person who trained staff: _____

Date of training: _____