

MEDICATION AUTHORIZATION



Child's name: _____

Date of birth: _____

Name of medication (including strength): _____

Route of administration: _____

Dosage and frequency: _____

Possible side effects: _____

Child's known allergy: _____

Symptoms: _____

I certify that, in my opinion, it is medically necessary that the medication described above be administered by Preschool staff during a life threatening situation.

Signature of Physician

Telephone number

Date

I certify that I am the parent/guardian of the above referenced child and request that the Preschool staff administer the medication prescribed above to my child during Preschool hours if necessary. I understand that the person who will administer the medication may be inexperienced. I also agree to furnish said medication in the container supplied by the pharmacy with the label intact.

Signature of Parent/Guardian

Date

Fairfax United Methodist Church Preschool
10300 Stratford Avenue
Fairfax, VA 22030
703-591-3177

