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. This authorization is valid from the date below through the end of the current school year.

_____ _____

Signature of Parent/Guardian Date

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

Accredited by the NAEYC Academy for Early Childhood Program Accreditation