Arlington Unitarian Cooperative Preschool

Authorization to Administer Medication

Name of child _____

Date _____ Name of medication _____

Date prescribed _____ Prescription number _____

Date of last dose _____

For Parent to complete:

I (We), _____(parents or guardians) give permission to _____ (name of authorized child care staff) to administer _____ (dose) of _____ (name of medication) to my child, _____ (name of child) at approximately _____ (time[s] dose due) on _____ (dates and days) for _____ (reason for medication).

I (We) understand that the staff of Arlington Unitarian Cooperative Preschool (AUCP) are not trained medical personnel. I (We) further understand that there are risks inherent in the administration of any medication of injection and that in giving the staff of AUCP permission to administer _____ (name of medication), I (we) agree to assume the risks of injury resulting from the administration of such medication. I (We) hereby waive and release AUCP, its Board of Directors and its employees against all claims resulting from the administration of _____(name of medication).

Parents' or guardians' signatures:

_____ _____

Home phone _____
Work phone _____
Cell phone _____

Home phone _____
Work phone _____
Cell phone _____

For physician to complete:

Possible side effects to watch for with this medication include _____

_____

This authorization is effective until _____ (date)
Specific instructions (if any) _____

_____

Physician's name _____ Phone number _____

Physician's signature _____