Chapel Hill Preschool
Medication Permission Form

P.O. Box 829 Gig Harbor, WA 98335 253-853-0234

Student's Name _____Birth date_____

Teacher_____

Name Of Medication Dosage Method of Administration Time of Day

_____ _____ _____ _____

Reason for medication to be given during preschool hours

_____

Anticipated action _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing (date) _____ through (date) _____

As there exists a valid health reason which makes administration of the medication advisable during preschool hours or during such time that the student is under the supervision of school/ church personnel, such medication may be administered by medically untrained employees.

_____

Physician's/Dentist's Signature Date

_____

Address

_____

Phone Number Fax Number

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified student in accordance with the prescription or doctors instructions for the period beginning (date) _____ through (date) _____

_____

Parent/Guardian Signature Date

Phones— Home: Mobile: Work: