Saint James Preschool
Grow, Explore, Discover, Imagine Together

581 Valley Road Montclair, NJ 07043

Authorization to Give Medication at St. James Preschool

(One form per medication, per health event)

The following information is to be completed by the child's health care provider:

Child's name: _____Class: _____ Birth date: _____ Wt: _____

Medication: _____ Allergies: _____

Dosage: _____Time of day to be given: _____

Purpose of medication: _____

Special instructions: _____

Possible side effects: _____

Start date: _____ End Date: _____

_____ _____ _____

Signature of health care provider (Required for Prescription Medications) | Phone number | Date

The following is to be completed by the parent or guardian:

I hereby give permission for my child, _____ to receive the above medication, according to the listed directions and cautions, from the Director, or the Director designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give an accurate dose of the medicine. I authorize the Director or the Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Executive Director or the Executive Director's Designee to contact the health care provider regarding my child's health, if necessary.

I usually do the following to make giving medication to my child easier: _____

_____

Amount of medication brought to St. James Preschool: _____

Date: _____ _____

Signature of Parent or Guardian

Date medication is returned to Parent: _____