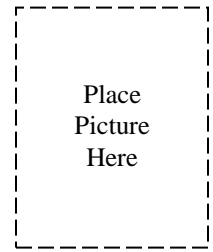


# Permission to Administer Medication

Please fill out one form for each Medication.



**Student's Name:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_

**Description of Medication:** \_\_\_\_\_

**Date of Expiration:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

**Symptoms that *may lead to* the need for medication:**

\_\_\_\_\_  
\_\_\_\_\_

**Symptoms that *require* administration of medication:**

\_\_\_\_\_  
\_\_\_\_\_

**Procedures to follow if medication is required:** Please include dosage.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

I give Valley Preschool permission to display my child's medication procedures and photo for teachers, volunteers, parents, and visitors to see. I have provided Valley Preschool with the medication listed above to leave at school and administer as directed by my child's physician. The medicine I have provided is in its original container and has the original label with my child's name and prescription information. I will replace when the expiration date approaches. I understand if I fail to replace before the expiration date, staff will not be able to administer the medication. This medication will only be given to my child and a record of administration will be kept in my child's file at school.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

