PHYSICIAN'S ORDERS FOR PRESCRIPTION MEDICATION AT ITBP AND FMDO

Whenever possible, the parent and physician will design a schedule for giving medication outside of school hours. Medication is ordered to be given to a student at Preschool only when necessary. **Only PRESCRIPTION medication will be administered**. Medication may be kept by the teaching staff and administered by non-licensed preschool staff or parent or other designated personnel.

The Preschool accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Student Name: Name of Physician:
Name of Medication:
Diagnosis for which medication is given:
Form and dose:
If medicine is to be given "WHEN NEEDED," describe indications:
Special Instructions:
Student: ☐ may ☐ may not keep medications on person and self-administer
Side effects of drug (if any) to be expected:
Length of time this authorization is valid:
Date: Physician's Signature:

PARENTS PERMISSION

I request that my child be allowed to take prescription medication as described above. The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, amount to be taken, and the time of day to be taken. The physician's name is on the label. No expired medications will be accepted. **I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.** This authorization is good for the current school year only. In case of necessity the Preschool may discontinue administration of the medication with proper advance notice. I am the parent or the legal guardian of the child named.

Date:_____ Signature of parent or guardian:_____

Student's home address:_____

Emergency day time phone:_____

Physician and Parent have discussed and agreed upon the Preschool's Allergy Care Questionnaire:

Parent Initials_____ **Physician Initials_____**

Authorization for Administration of

OVER THE COUNTER Medications at Preschool

In the Beginning Preschool
Sammamish WA

Student Name:_____Class_____

Name of Medication:_____

Dosage: _____ Method of Administration:_____

Scenario/reason for giving this medication to student:_____

_____

Anticipated Reaction:_____

Possible Side Effects:_____

Parent/Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the school to administer the above identified medication to the above identified student in accordance with the instructions given. This authorization is good for the current school year only. In case of necessity the Preschool may discontinue administration of the medication with proper advance notice. Medication must be supplied to the school in the original unopened container and cannot be expired medication.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with my own, the manufacturer's and/or physician's directions.

Parent/Guardian Signature:_____

Emergency day time phone numbers:_____

Date:_____

If applicable, please have your physician sign to authorize the administration of medication(s) listed above.

Physician's Name

Signature:_____

Print_____

Date:_____