Early Learning Academy

AUTHORIZATION FOR MEDICATION

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time Medication is to be given: _____

(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

Please list all medications your child is currently taking – Include Name, Dosage, Times:

_____

_____

_____ _____

PARENT'S SIGNATURE DATE