Watertown-Mayer Public Schools • ISD #111
Young Royals Preschool

Authorization for Administration of Medication

Parents/Guardians please note:

1) **Over-the-counter** medications require a **parent/guardian signature.**
2) All medications including Tylenol/Ibuprofen etc. for **children in licensed child care** require a physician's signature
3) **Prescription** medications require a **parent/guardian signature AND physician's signature.**
4) All medications must be in the **original, labeled bottle**
5) Prescription Medications must not be in an expired bottle.
6) Kids' Company does **NOT** supply any medication.

_____ _____ _____ ____ / ____ / ____

Student's Name **Grade** **Age** **Date of Birth**

Medical Condition	Medication	Dose	Time of Administration	Possible Side Effects

Other Considerations/Directions:

_____

_____

Parent/Guardian Authorization

1) I request that the above medication be given during **Kids' Company Program Hours**
2) I release the **Program** personnel from liability in the event adverse reactions result from taking the medication.
3) I will notify the **Kids' Company** of any change in the medication.
4) I give permission for the **Kids' Company Staff** to communicate with school/**program** personnel about the student's health condition and action of the medication as needed.
5) I give permission for the **Kids' Company Staff** to consult with the student's physician regarding any questions/concerns that may arise with regard to the medication or medical condition being treated by the medication.
6) I give permission for the medication to be given by designated **Kids' Company Staff** I as delegated by the **Kids' Company Coordinator**

_____ My child may carry his/her inhaler and or epi-pen _____ My childs' inhaler and or epi-pen will be left with Kids' Co

_____ Medication should be sent along with Staff on field trips.

_____ _____

Parent/Guardian Signature Date

Physician/Licensed Prescriber Authorization

I have prescribed the medication listed above for this child and request it to be given during school hours by school personnel.

Licensed Prescriber Signature: _____ Date: _____

Clinic: _____ Phone#: _____ Fax#:_____

Please Email this signed form to michelle.hess@wm.k12.mn.us or fax to 952-955-0201

Authorization for Administration of Medication
Tracking Log (Must include Page 1- Authorization)

_____ _____ _____ ____ / ____ / ____

Student's Name **Grade** **Age** **Date of Birth**

Medication Name	Expiration	Quantity	Date	Staff Int.

Medication Administration Log

Date	Time	Dosage	Staff Initials(2)

Emergency Contact:

Name/Relationship: _____ Phone#:_____