Danville Head Start Pre-K

MEDICATION PERMIT

Please have this form completed by the doctor.

TO THE PHYSICIAN:
Please confer with the parent to arrange medication time intervals to avoid school hours whenever possible. When medication must be given during school hours, school policy permits designated school personnel to administer prescribed medication provided to the school in the original, labeled pharmaceutical container with written permission from the personal physician.

DATE:_____

NAME OF STUDENT: _____ **DOB:**_____

DIAGNOSIS: _____

MEDICATION/DOSAGE: _____

TIME/ROUTE:_____

MEDICATION EXPIRATION DATE:_____

DURATION OF TIME TO BE ADMINISTERED IN SCHOOL: _____

SPECIAL INSTRUCTIONS: _____

_____

LIST ANY OTHER MEDICATION THAT HAS BEEN PRESCRIBED: _____

PHYSICIAN'S SIGNATURE: _____

TO THE PARENT:

I, the parent/guardian, authorize the Head Start Employee or her designee to administer the above medication as prescribed. I further state that I will not hold any person/organization liable while carrying out my directions.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

If medication is sent to school with the student, please put the container and this form in an envelope and give it to a staff person. This form will be retained in the child's health file in the office.