AUTHORIZATION TO ADMINISTER MEDICINE – for Nebulizer or inhaled meds

To _____
Child's Name

For prescribing physician to complete:

Administer _____ by way of _____,
Medication Route

in the amount of _____ at _____ for _____,
Dosage Time # of days

for _____,
Reason for medication OR SYMPTOMS REQUIRING USE OF MEDICATION

being alert to any side effects of :_____.

Usual (baseline) respiratory rate for this child:_____

Seek emergency medical care if child has:
- Respiratory rate greater than _____
- Coughs constantly
- Hard time breathing
- Trouble walking or talking
- Lips or fingernails are grey or blue

Physician's Signature:_____

Phone: _____ Date: _____

* * * * * * * * * * * * * *

I, _____ (parent or guardian) authorize Little Lights Christian Early Learning Center to administer the above prescription or over-the-counter medication as directed above. The medicine will be brought to school in the original container with the prescription label attached which includes the name of the physician, the name of the medicine, the dosage, the child's name and the date. It must be a current prescription. A separate authorization form will be completed for each medication my child is to receive.

_____ _____
Parent Signature Date

* * * * * * *

Record of medication administered:

Date	Time	Amount	By Whom
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Info provided to:

Little Lights
Christian Early Learning Center
15150 Washington St
Thornton CO 80023
720-872-2200