AUTHORIZATION TO ADMINISTER MEDICINE

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 :____.

Physician's Name & Address:

__________________________ 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