Kingdom Kids Christian Preschool & Summer Camp

ROCHESTER, MINNESOTA

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION (TO BE RENEWED ANNUALLY)

Student_____ Date of Birth_____

School_____ Teacher_____

Parent(s)/Guardian(s)_____

Phone Numbers: Home _____ Work _____

I hereby request and authorize you to administer to the above-named student:

	MEDICATION	DOSAGE	TIME	DURATION	PRESCRIPTION	SELF-ADMINISTER
1.					Yes/No	Yes/No
2.					Yes/No	Yes/No
3.					Yes/No	Yes/No

Diagnosis/medical reason for medication _____

Other medications the student is taking _____

Allergies _____

Other recommendations/unusual side effects _____

Required for Prescription Medications and Over-the-Counter Medications that exceed package recommendations:

Physician's signature _____ Date _____

Print physician's name _____ Phone No. _____

PARENT/GUARDIAN AUTHORIZATION FOR *STAFF* ADMINISTRATION

1. I request that the above medication(s) be given to my student during school hours.

2. I will immediately notify the school of any change in the medication or physician's order, dosage change, frequency, or duration of administration.

3. I give permission for preschool staff to consult with this student's physician concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.

_____ _____
Parent(s)/Guardian(s) Signature Date

4. Field Trips – I give permission for school personnel to administer the medication(s) on a field trip, as necessary, following school procedure.

_____ _____
Parent(s)/Guardian(s) Signature Date