Authorization for Medication

to be given at Light of Christ Preschool

Date ________________________________

Child's Name____

Parent/Guardian's Name ____

Name of Medication____

Date Begin Medication ____________________ End Medication________________

Instructions for giving medication____

____

____

____

Doctor's Name and Telephone Number _____________________________________

Last time medication was given, if applicable________________________________

I understand that the Light of Christ Staff are NOT medical personnel.

Parent/Guardian Signature____