Written Permission & Instruction for Medication by Parent or Legal Guardian

Name of Child: _____ Class: _____ Age: _____
Weight: _____

Name of Child Care Program/Provider: Shelburne Nursery School

Health Care Provider who wrote the prescription: _____
Phone: _____

Pharmacist who filled the prescription: _____
Phone: _____

Name of Medication: _____ **Dosage:** _____
How to Administer: _____

Purpose of Medication: _____

Time(s) of day medication is to be given: _____
Date prescribed: _____ **Date last dose due:** _____

Possible side effects: _____
Storage Instructions: _____

I hereby give permission for Shelburne Nursery School to give the above medication to my child, Thomas Wockenfuss as instructed above.

Signatures:
Parent/Legal Guardian: _____ Date: _____

Child Care Provider: _____ Date: _____
(Shelburne Nursery School Teacher)

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled.

I, _____hereby authorize Shelburne Nursery School to call the health care provider prescribing the medication described above to follow up with any questions concerning the administration of the medication, any side effects, or other concerns related to the administration of my child's medication.

I, _____ hereby authorize _____
(name of child's health care provider)
to disclose information about my child's medication, side effects, or other concerns related to the administration of my child's medication by Shelburne Nursery School. The purpose of this disclosure relates to Shelburne Nursery School's administration of medication to my child in my absence.

I understand that by signing this authorization, I am authorizing Shelburne Nursery School to disclose my child's health information as described above. I also understand that this health information could be re-disclosed by Shelburne Nursery School as necessary in caring for my child, and if so, may not be subject to federal or state laws protecting its confidentiality.

This authorization expires when my child no longer needs the medication. I have the right to revoke this authorization at any time by doing so in writing, except to the extent that the child's health care provider has already relied upon it.

Signature: _____ (parent / legal guardian)
Date: _____ (circle one)

Parent phone number: _____

Shelburne Nursery School's Phone Number: 802-985-3993