

The Early Years, Inc
Authorization-Nonprescription Medication

Student's Name: _____ Date: _____

Teacher: _____ Age: _____

I hereby request that The Early Year's, Inc. through its designated authority, supervise/assist in the administering of medication to my child, _____, according to the instructions contained on the physician's statement or label. I release The Early Years, Inc. and their employee from any liability for administering this medication.

Name of Medication: _____ Times to be given: _____

Dosage: _____

Possible side effects: _____

Parent's Signature

Date

The Early Years, Inc
Authorization-Nonprescription Medication

Student's Name: _____ Date: _____

Teacher: _____ Age: _____

I hereby request that The Early Year's, Inc. through its designated authority, supervise/assist in the administering of medication to my child, _____, according to the instructions contained on the physician's statement or label. I release The Early Years, Inc. and their employee from any liability for administering this medication.

Name of Medication: _____ Times to be given: _____

Dosage: _____

Possible side effects: _____

Parent's Signature

Date