The Early Years, Inc
Authorization-Prescription 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. I release The Early Years, Inc. and their employee from any liability for administering this medication.

_____ _____
Parent's/Legal Guardian's Signature Date

Physician's Statement: _____

Name of Medication:_____

Dosage:_____

Approximate time(s) medication is to be given during school day:
_____

Expected duration of administration of medicine (indicate appropriate one):
Last day to be given:_____ Until further notice:_____

Remainder of the year_____

Possible side effects, if any: _____

Suggested basic first aid procedures for handling possible side effects:
_____
_____
Other Comments:
_____

Is this student in need of assistance in administering this medicine?
YES_____ NO_____
If yes, explain assistance needed:_____
_____

Physician's/Licensed Signature_____
Physician's Address_____

_____ _____
Physician's Name (Please Print) Physician's Phone Number