AUTHORIZATION TO ADMINISTER MEDICATION

Rainbow Early Learning Center has my permission to administer medication to my child as indicated in this form.

Child's Name _____Medication/Pres. No._____

☐ Short Term – not to exceed 10 Days
☐ Long Term—medication administered for more than 10 Days, Physician's signature required.

Dosage and Times to be given:_____

We are not able to accept authorization on an "as needed" basis.

Precise times or intervals or specific symptoms must be specified.

Special Instructions(if any):_____

Date :_____ This authorization is effective until:_____

Parent's OR Guardian's Signature: _____Date: _____

Complete for Long-Term Use ONLY. To be completed by Physician.
I certify that, in my opinion it is medically necessary that the medicine described above be administered to _____ during center hours and that this medicine can be administered by center staff.
Physician's Printed Name:_____
Physician's Signature:_____
Date:_____
This authorization is effective until: _____