St. John's
LITTLE LAMBS
PRESCHOOL

Medical Authorization

Full Name of Student_____ Teacher_____

Name of
Medication_____

Amount to be given: _____

Time to be given: _____

Date to Begin: _____ Date to end: _____

Is this information consistent with the instructions on the bottle? _____

Reason for taking medication:

_____

_____

Comments/potential side effects:

_____

_____

List any drug allergies/reactions:

_____

_____

I authorize St. John's Little Lambs School to administer the above medication to my child. I understand that an additional authorization will be necessary if the dosage of medication is changed. It is understood by the undersigned that St. John's Little Lambs School nor its personnel will be held liable for the administration of the above medication or for its possible side effects.

Parent's Signature_____**Date**_____