Elmwood Early Learning Center
Authorization to Administer Medication
213 S. Scott Street, Elmwood, WI 54740
Phone: (715) 639-2711 / Fax (715) 639-3110

Child's Name: _____ Date of Birth: _____

Parent Name: _____ Daytime Phone: _____

I/We: • give consent for center personnel to administer the following medications according to the directions below •consent to the free exchange of information regarding this medication between the licensed prescriber/physician and center personnel •agree to notify the center in writing of any changes or termination of this request • understand that the medication must be delivered to the center in the original over-the-counter package detailing instructions for medication administration including student name, drug dosage, time/ • agree to hold center personnel harmless in any and all claims arising from the administration of this medication during center hours •understand that this medication order is in effect for the current year only

NON-PRESCRIPTION MEDICATIONS					Condition under which medication should be given:
Medicine Name	Route	Dose	Frequency/Time	Duration	
				From: To:	
				From: To:	
				From: To:	

Parent/Guardian Signature: _____ Date: _____

PRESCRIPTION MEDICATIONS - **Physician Signature Required					Direct contact with the physician shall be made for the following reasons:
Medicine Name	Route	Dose	Frequency/Time	Duration	
				From: To:	
				From: To:	

According to center policy, no prescription medication will be administered to a child without written medication orders from parent and physician. These orders must include the name of the drug, dosage, frequency/time to be administered, length of time medication is to be administered, reason medication is prescribed and conditions under which contact with the physician should be made. These directions and all of the above directions will be followed for all prescription medications.

I am prescribing medication for the above named child who has a diagnosis of: _____

Parent/Guardian Signature: _____ Date: _____

Licensed Prescriber/Physician Signature: _____ Date: _____

Prescriber/Physician Name: _____ Phone: _____

Office/Clinic Address: _____ Fax: _____