Medication Authorization Form Instructions

The Medication Authorization Form **only** needs to be completed if any medication needs to be administered at preschool during the school year. This form **only** needs to be submitted if your child must have medication available at school. Please carefully review the list of Medication Requirements. All medications must be checked for compliance with these requirements in the Preschool Office before it can be given to your child's teacher. **You must use the Preschool Medication Authorization Form**, not a generic form or a form from another school.

1. All medications kept at school require a Medication Authorization Form signed by both physician and parent:

   - The Physician Authorization section of the form must be completed and signed by your child's physician. The medicine name must match exactly the name listed on the Authorization Form.
   - The Parental Permission section of the form must be completed and signed by a parent.

2. Medication containers must be labeled in permanent ink with the child's name and the dosage amount.

3. **All medication must be in its original container**. Prescription medication must be in the original container with the prescription label attached, if applicable. Medication should be brought to school in their boxes, as the prescription label is attached to the box. We can copy the label for parents who request it so that they may retain the prescription information, such as refills, date of expiration, etc. Medications should be in child resistant containers.

4. If possible, please send in medication that will not expire during the school year. If this is not possible, please make a note of the expiration date and replace the prescription before that date.

5. For liquid oral medications, such as Benadryl, the parent must provide the administration device with clearly marked measurements (medicine spoon, medicine cup, dropper, or syringe). This should also be marked with the child's name.

6. The parent should bring the medication to the Preschool Office in a large zip-loc bag labeled with his or her child's name and class to be checked for compliance with licensing requirements. **Please do not send medication in your child's school bag.**

7. Parents of children with life threatening allergies requiring epinephrine (such as EpiPens) *must* bring medications to school before the child can begin. Please pick up medication from your child's teacher on the last day of school.

Section A: To be completed by parent/guardian

Medication Authorization for: _____
<div align="center">(child's name)</div>

I authorize Herndon United Methodist Church Preschool to administer the medication as specified in Section B of this form. I further certify that it is medically necessary for this medication to be administered.

_____ _____ _____
<div align="center">(Parent/Guardian Name—Please Print)   (Parent/Guardian Signature)   (Date authorized)</div>

Section B: To be completed by Physician for ALL medications kept and administered for more than 10 days (except diaper cream/ointment) and for all Emergency Epinephrine and Nebulizers. Parent/guardian may complete for diaper cream/ointment and for medications to be kept and administered on site at HUMC Preschool for 10 days or less (Exception: Emergency Epinephrine and Nebulizers).

Child's Name:_____Date of Birth:_____Child's Known allergies: _____

Name of Medication (Including strength):_____Dosage: _____Route: _____

Frequency to be administered (include time): _____

Symptoms that necessitate administration: _____

 Possible side effects (package insert or pharmacy printout with complete list of possible side effects must be included):

_____

What action should HUMC Preschool take if side effects are noted:___contact parent_____contact prescriber

___other (explain): _____

Special Instructions (package insert or pharmacy printout must be supplied for complete list of special instructions):

_____

Reason child is taking the medication: _____

I certify that it is medically necessary for the medication listed to be administered to the child listed above. **This authorization is effective for one year from date authorized below unless otherwise noted.**

_____   _____
<div align="center">Date Authorization Completed   Printed Prescribers Name for long term medications (longer than 10 days)</div>

_____   _____
<div align="center">Prescribers phone number   Licensed authorized prescriber's signature</div>

Section C: To be completed by HUMC Preschool

My signature indicates that all information needed to give this medication has been given to HUMC Preschool.

_____   _____
<div align="center">Date Received   Authorized Signature</div>