Verifying Teacher Initials:

_____

Bright Start
Learning Center & Preschool

AUTHORIZATION TO ADMINISTER MEDICATION

Bright Start 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 school days**
- ☐ **Long Term – medication administered for more than 10 school 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: _____

Medication to be returned to Parent on: _____

Date Contacted to Pick Up Medication: _____

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: _____

Medication was administered at the following dates and time:

Date	Time	Amount Given	Adverse Reaction (if any)	Errors (if any)	Signature of Person Administering Medication

Date	Time	Amount Given	Adverse Reaction (if any)	Errors (if any)	Signature of Person Administering Medication