Fruitport Early Childhood Center
Authorization for Medications to be Taken During School Hours

The following section is to be completed by PARENT/GUARDIAN:

_____

CHILD'S NAME (LAST, FIRST) **BIRTH DATE**

_____

ADDRESS

(PARENT, PLEASE INITIAL EACH LINE)

_____ I request that my child <u>be assisted</u> in taking the medicine(s) described below, at childcare/school, by authorized personnel.

_____ I will assume responsibility for safe delivery of the medication to the ECC office.

_____ I will notify the ECC program immediately, in writing, if there is any change in the use of the medication or the prescribed treatment.

_____ I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ I authorize staff affiliated with Fruitport Community Schools to exchange information concerning medication, medical history, or other pertinent medical information regarding my child.

_____ _____

Parent/Guardian Signature **Date**

(_____)_____ (_____)_____

Home Phone **Cell Phone**

The following is to be completed by your <u>PHYSICIAN for prescribed medications or OTC medication if container directions indicate consultation from a doctor is necessary for dosage amount,</u> or by <u>PARENTS for non-prescribed medications:</u>

Diagnosis for which medication is given:_____

_____ _____

NAME OF MEDICATION DOSAGE (mg)

Time of day medication should be dispensed: _____

Termination date of medication: _____

If medication is to be given "when needed", describe indications: _____

_____

Other information: _____

_____ _____

Date **PHYSICIAN'S SIGNATURE** (or parent's signature for non-prescription medicines)

Physicians please fax to: Fruitport Community Schools, Early Childhood Center **FAX (231) 865-4103**
Questions, please call (231) 865-4102

Medication Administration Log

Child's Name__________________________________

Date	Name of Medication/Dosage	Time Given	Administered by	Witness