Good Beginnings Preschool & Kindergarten

EMERGENCY MEDICATION DISPENSING FORM

Medication will be administered to students during school hours only when such medication is needed in an emergency situation. No medication can be administered to any student without proper completion of this form.

All medication to be administered by school staff must be delivered in the original container with the prescription label to the school office along with the Emergency Medication Dispensing Form.

TO BE COMPLETED BY PHYSICIAN/DENTIST:

Student's name: _____ Age: _____

Name of Medication : _____

Specific Dosage:_____ Frequency: _____

Reason for Medication:_____

Action Plan During Emergency: _____

_____

It is my understanding that the staff of Good Beginnings Preschool & Kindergarten charged with administration of this emergency medication/treatment during school hours, rely on directions contained in this document. I further certify that I am the physician or dentist who prescribed the medication/treatment and the above named student is under my supervision as a patient.

Signature of Physician/Dentist: _____

Printed Name of Physician/Dentist: _____

Address: _____

Telephone: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

As parent/guardian of the above named student, I request that the medication/treatment described above be administered to my child in an emergency situation and release Good Beginnings & Preschool and its employees from liability for any detriment my child may suffer as a result of this request.

Signature of Parent/Guardian: _____

Printed name of Parent/Guardian: _____

Date: _____