Haygood Preschool

AUTHORIZATION FOR MEDICATION- Student Action Plan

(Check one) Prescription Medication__________Over-the-Counter Medication_________

Student's Name: ___________________________Date of Birth: ___________Class:___________

Teachers: __________________ Parent Phone #: ____

Allergies: ____

Medication Protocol: please list in order the medications to be given. Ex. Benadryl may be administered first, followed by EpiPen.

1. **First**
   Signs/Symptoms____

First Medication____

Dosage____________________ Method___________________ Frequency_____________________

2. **Second**
   Signs/Symptoms____

Second Medication____

Dosage____________________ Method____________________ Frequency____________________

Other instructions:

Physician's Name (Printed)__________________________ Physician's Phone Number_________________

PARENTAL PERMISSION FOR MEDICATION

Student's Name: _______________________Date of Birth: ______________Class: __________

I grant the teachers and staff members of Haygood Preschool permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events.

NOTE:

- **Medications must be supplied in the original container.**
- It is your responsibility to notify the school when there is a change in medication regimen.

____________________________________ ____________________________________

Parent / Guardian Name (Printed) Signature of Parent / Guardian

____________________________________ ____________________________________

Date Signed Parent Primary Phone Number