Lewisville United Methodist Church Preschool, Inc.

Permission to Administer Medication

PLEASE NOTE: All medication must be in original containers with child's name. Physician's name, directions for use and date clearly visible.

I request that my child, ____ be given the following medication, medical check/procedure (i.e. sugar levels):

____

on the following date(s)____

at the following time(s) of day: _________________________________

The dosage to be given is____

Physician's
Name____Phone_________________________

DO NOT PUT MEDICATION IN CHILDREN'S BACKPACK OR LUNCH BOXES

____ __________________________

Signature of Parent/Guardian Date

* * *

Lewisville UMC Preschool Use Only

Medication/Medical Check Given:

Date	Time	Results	Staff Member Administering Medication
__________	_________	_________	______________________________________
__________	_________	_________	______________________________________
__________	_________	_________	______________________________________

__________	__________	__________	____
__________	__________	__________	____

Lewisville UMC Preschool Use Only

Medication/Medical Check Given:

Date	Time	Results	Staff Member Administering Medication
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