

Date: \_\_\_\_\_

## **AUTHORIZATION TO DISPENSE MEDICATION**

The school personnel at Southeastern Preschool are hereby requested to administer medication under the following directions:

Child's Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Time to be administered: \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Parent/Guardian signature

Date: \_\_\_\_\_

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