

# St. Stephen's Preschool

24901 Orchard Village Road  
Santa Clarita, CA 91355  
(661) 259-8527 FAX (661) 259-6683  
director@st-stephens.org school@st-stephens.org

## Physician's Authorization to Administer a Medication

Name of student \_\_\_\_\_ birth date \_\_\_\_\_

The above named child is enrolled in a program at St. Stephen's Preschool. I hereby authorize release of medical information contained in this report to the above-named preschool.

Signature of parent/legal guardian \_\_\_\_\_ Date \_\_\_\_\_

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

Instructions for the administration of the medication \_\_\_\_\_

Potential side effects and expected response to the medication \_\_\_\_\_

Conditions under which the medication is NOT to be administered \_\_\_\_\_

Dose to be administered \_\_\_\_\_

Actions to be taken in the event of side effects or incomplete treatment response \_\_\_\_\_

Actions to be taken in the event of an emergency \_\_\_\_\_

The medication:

\_\_\_\_\_ may be stored at room temperature      \_\_\_\_\_ must be stored in the refrigerator

other conditions for storage \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Phone number of physician \_\_\_\_\_

E-mail of physician \_\_\_\_\_

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