ADOLPH & ROSE LEVIS JEWISH COMMUNITY CENTER
Betty & Marvin Zale Early Childhood Learning Center

PARENT PERMISSION FOR ADMINISTERING MEDICATION

Child's Name:_____ Date of Birth:_____

Diagnosis:_____

Medication:_____ Dosage:_____

Date to be administered:_____ Time to be administered: _____

Symptoms signaling need for administration of medication:_____

Location of Medication:

- ☐ Refrigerated Lockbox
- ☐ With Teacher
- ☐ Locked Classroom Cabinet or Closet

I understand:

- Medication authorization is valid for one year and must be renewed at the beginning of each school year.
- Medication must be in original container and labeled to match physician's order.
- Parent will supply medication to be kept at school as well as additional supplies for other programs as necessary.
- Medication may not be sent to or from school in child's backpack or lunchbox.
- A log will be kept at school in order to record administration of medication.
- Emergency Personnel (911) will be called if Adolph and Rose Levis JCC/Betty & Marvin Zale Early Childhood Learning Center staff deems it necessary. All efforts will be made to contact me if an emergency arises.

I give permission for information regarding diagnosis and/or medication administered to be shared with appropriate staff in order to ensure my child's health and safety.

I hereby give permission for my child to receive medication during school hours administered by Adolph & Rose Levis JCC Zale Early Childhood Staff. I understand that Adolph & Rose Levis Jewish Community Center/Betty and Marvin Zale Early Childhood Learning Center undertake no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release Adolph & Rose Levis Jewish Community Center/Betty and Marvin Zale Early Childhood Learning Center and its employees from any and all liability that may result from my child taking the medication.

_____	_____	_____
Parent/Guardian Signature	Date	Emergency Phone # (Home, Cell, Work)

Physician Authorization

The above named medication has been prescribed for _____ and is to be administered as described.

Additional information or specific instructions:_____

Physician's name (print):_____ Telephone #:_____

Physician's Signature:_____ Date:_____