Glenside Bible Church Nursery School
447 N. Keswick Avenue
Glenside, PA 19038
215-887-2289
glensidebiblechurch.org

Authorization To Administer Medication

CHILD DETAILS

Full Name: _____ Age: _____ D.O.B.: _____

MEDICATION DETAILS

Name of medication: _____

Reason For medication: _____

Time medication is to be given: _____

Amount of medication to be given (Dose): _____

Frequency: _____

Route of administration (Oral/Topical/Inhaled/Other): _____

Dates to be given: _____

Special directions (Take with water/ take before eating): _____

_____

_____

For Prescription Medication Only

Prescribing Physician: _____ Contact: _____

I authorize Glenside Bible Church Nursery School Staff to administer the medication outlined above to my child according to the specified dosage, administration, and duration period for the indicated condition.

I understand that all prescription medications must be clearly labeled with my child's name, dosage amount, and frequency. I understand that expired medications will not be administered to my child at any time.

Parent/Guardian Signature: _____ Date: _____