Waiver for the Distribution/Administration of Medication

One form must be filled out for each medication.

This form must be complete and signed by both parent and physician in order for the medication to be administered.

Child's Name: _____ Home Phone: _____

Medication Start Date: _____Medication End Date: _____

Medication Name: _____Refrigerate? _____Yes _____No

Reason for Medication: _____Any side effects? _____

Dosage: _____ Time to be administered: _____

Physician Name: _____Physician Phone Number: _____

Physician Signature: _____ **Date**: _____

Any prescription medications must be in the original pharmacy labeled container, and any over the counter medications must be clearly labeled with the child's first & last name. All medication must be current and replaced by the expiration date.

The undersigned hereby acknowledges and represents that s/he is the parent, legal guardian or person legally responsible for the above named child while s/he is under the supervision of the programs sponsored and operated by Little Ones.

The undersigned further acknowledges that s/he has requested that Little Ones staff, its employees and/or duly authorized agents administer or assist in administering the above indicated medication while the above named child is under the supervision of Little Ones.

Now, in consideration of the administering or assistance in administering said medication, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify Little Ones Preschool, Inc., its employees and duly authorized agents of and from any and all claims, demands, suits, actions, and liabilities or responsibilities of whatsoever kind or nature, arising out of or in connection with the administering or assistance in administering of said medication.

Parent Name: _____

Parent Signature: _____Date: _____