Shorecrest | Preparatory School

SHORECREST PREPARATORY SCHOOL, INC.
ADMINISTRATION OF MEDICATION

Date: _____

Student Name: _____

Please administer _____
(name of medication and dosage)

_____

to my child: _____

__ daily at the following times:

_____ _____ _____

or,

__ as needed for: _____
(condition or problem)

until the following date: _____.

PARENT OR LEGAL GUARDIAN PLEASE SIGN BELOW

I give my permission to Shorecrest Preparatory School to give my child the above prescribed medication. I will not hold the Shorecrest Preparatory School responsible in the event of a possible error.

_____ _____
Date Signature of parent or legal guardian

ALL MEDICATIONS MUST BE IN ORIGINAL LABELED PRESCRIPTION CONTAINERS