



Parent Medication Authorization

The Harvest School does not administer any over-the-counter drugs due to possible side effects, unless a specific written order is received from the child's physician.

Child's Name _____

Name of Medicine _____ Prescription # _____

Dosage _____ Expiration Date _____

Specify dates to administer: _____

Instructions (mouth, skin, inhale. Etc) _____

Medication will only be administered at 12pm

I hereby request that the appropriate representative of The Harvest School administer the medication to my child according to the instructions stated above. I hereby release The Harvest School and any of its employees from any liability for administering this medication. I agree to take home the medication at the end of each day.

Signature of Parent _____ Date _____

TO BE FILLED OUT BY THE HARVEST SCHOOL:

Date	Time	Dosage	Signature	Any Reaction?

Must be filed Bi-weekly in the child's file.