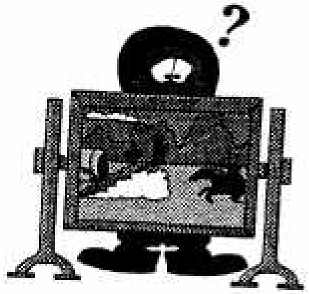

Pre-School - 3rd Grade
4701 West Washington Boulevard
Los Angeles, CA 90016
(323) 934-6868
FAX# (323) 934-6869

MEDICATION CONSENT FORM
PARENTS

IT IS A MUST THAT ALL INFORMATION BE COMPLETED OR THE STAFF WILL NOT BE ABLE TO GIVE MEDICATION TO YOUR CHILD

ONE FORM PER PRESCRIPTION
ONE PRESCRIPTION PER CHILD
THIS FORM IS VALID FOR 5 DAYS ONLY

IF YOU INDICATE ONLY GIVEN WHEN NECESSARY, THE SCHOOL WILL CALL YOU THE PARENT TO GET APPROVAL FOR THE MEDICATION. IF YOU CAN'T BE CONTACTED THE SCHOOL WILL NOT GIVE THE MEDICATION

Child's Name ______________________________ Date ______________

Name of Medicine ______________________________ Date Prescribed ______________

Prescription # ______________________________ NON Prescription (Circle) Yes No

Doctor's Name ______________________________ Doctor's Phone # ______________

Parent/Guardian Signature ______________________ Parent/Guardian Phone # ___________

Should Medication be Refrigerated (Circle one) Yes No

Amount of Medication Given ________ Time Medication is to be given ______ a.m. ______ p.m.

* *

(Only fill out if Medication is to be given only when necessary)

Phone Number Called ______________ Talked to ______________ Time Called ___________

Is Prescription number same on form and bottle ______________________________

Is Medication NON Prescription (Circle) Yes No

TO BE FILLED OUT BY STAFF MEMBER

DAY OF WEEK	DATE	TIME GIVEN			STAFF MEMBER SIGNATURE		

DIRECTOR'S SIGNATURE ______________________________