Alameda Head Start/Early Head Start
2325 Clement Avenue, Alameda CA 94501 / Phone: (510) 629-6350 Fax: (510) 865-1930

Medication Authorization and Consent

Request for the Administration of Medication during School Hours

Child's Name_____

Condition for which medication is given: _____

Name of medication_____

Does medication require refrigeration? ☐ YES ☐ NO

Dosage and Method of Administration: _____

_____

Medication continued until: _____

Possible side effects: _____

Possible reactions to report: _____

Comments: _____

_____

_____ _____
Physician's Signature Date

_____ _____
Name of Clinic and Address Phone Number

Permission from Parent/Guardian to Administer Medication during School Hours

I understand that Alameda Head Start is not legally obligated to assist in the administration of medication to my child. Therefore, I agree that the employees of Alameda Head Start will be free of any and all liability that might result from these arrangements. I request that a member of the Alameda Head Start's Staff assist in the administration of medication to my child. I will notify the Alameda Head Start Program when the medication changes or is no longer necessary.

I certify that I have given my consent and have personally provided instructions for the following Alameda Head Start Staff:

_____ _____
Name and Position Name and Position

_____ _____
Name and Position Name and Position

to administer the medication listed above to my child: _____
Child's Name

Additional Comments: _____

_____

_____ _____
Signature of Parent/Guardian Date