Medical Action Plan

Permission to Administer Medications

Child's Name: **Birthdate:**

☐ My child has ***NO*** known allergies or medical conditions that require intervention at school

(if you checked this box, you do not need to fill out any further information)

☐ My child is allergic to: *(please specify allergen and reaction)*

_____

_____

☐ My child has the following conditions that may require medical intervention while at school *(please specify - allergies, asthma, etc.)*

_____

☐ My child may require the following medications: *(Epipen, inhaler, Benadryl, etc.)*

_____

This section must be completed by the child's physician:

Diagnosis:	Diagnosis:
Medicine Name:	Medicine Name:
Dosage:	Dosage:
Triggers:	Triggers:
Side Effects:	Side Effects:
When to administer medication:	When to administer medication:
When to repeat medicine:	When to repeat medicine:

Physician's Printed Name — Physician's Signature & Date

Practice Name: — Practice Phone Number:

I hereby authorize Grace Church Preschool staff to administer the above medications to my child according to the physician's instructions. I understand that I am responsible for assuring that medication made available to Grace Church Preschool is current (not expired) and I will advise Grace Church Preschool of any changes to this medical action plan.

Signature of Parent:_____ **Date:**_____