



UNITED METHODIST CHILDREN'S LEARNING CENTER

Physician Authorization/Instructions

Child's Name Date of Birth United Methodist Children's Learning Center Preschool

To be completed by Physician or Dentist:

1. Diagnosis:

2. Medication: A. B.

C. D.

3. Instructions and Method of Administration:

Blank lines for instructions and method of administration.

4. Duration of Medication:

5. Anticipated Reactions and/or side effects:

Blank lines for anticipated reactions and/or side effects.

Date

Physician's Signature

Special Instructions (If Any):

Blank line for special instructions.

I the undersigned give permission for the medication-trained staff of The United Methodist Children's Learning Center to give the above medication as prescribed and described to my child,

I release The United Methodist Children's Learning Center of all liability provided the above instructions have been observed.

Signature of Parent or Guardian

Witness