



# CHILDRENS' LIGHTHOUSE LEARNING CENTERS MEDICATION AUTHORIZATION FORM

**Child's Name:** \_\_\_\_\_ **DATE** \_\_\_\_\_

- I hereby request the staff to administer the medication named below to my child. I understand that all medications must be in the **original container and labeled with the child's name and with directions to administer the medication.** Prescribed medication must include the date and physician's name. **By signing below, I release Children's Lighthouse and it's staff from all liability for reactions that my child may suffer from this medication.**
- Children's Lighthouse requires that every medication be either a prescription or accompanied by a doctor's note if OTC (over the counter) Label requires.
- MEDICATION WILL BE GIVEN BETWEEN 11:30 – 11:55AM AND 3:30 – 4:00PM ONLY.

**SECTION BELOW FILLED OUT BY PARENTS ONLY**

**CLLC MANAGEMENT ONLY**

DATE	Name of Medication	Dosage	Circle Time to be Given		Parent's Signature	CLLC MANAGEMENT ONLY								
			11:30	3:30		11:30 Date/Time Given	Dosage Given	Signature of Staff dispensing medication	3:30 Date/Time Given	Dosage Given	Signature of Staff dispensing medication			
			11:30	3:30										
			11:30	3:30										
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