Central Kentucky CAC Head Start

MEDICATION AUTHORIZATION AND ADMINISTRATION

Date(s) Time	Dosage	Staff Member	Parent Signature

I give permission to my child to receive medication, listed on this form, at school. I waive any liability on behalf of the school. I understand that I have the ultimate responsibility of providing an adequate supply of medication to the school. My signature will give permission for exchange of verbal and written communication between the physician and school staff regarding my child's medical regime.

Signature:_____ Date:_____

Justifies Performance Standard: 1304.22

Policy Council Approved:_____