Please check one: ☐ US East (St. Peters) ☐ US West (Dardenne Prairie)

UNITED SERVICES MEDICATION CONSENT

CHILD'S NAME:_____ ROOM/S:_____

Physician Section

MEDICATION: _____

STRENGTH: _____

DOSE: _____

ROUTE: _____

TIME TO BE ADMINISTERED AT CHILD CARE/PRESCHOOL: _____

DURATION: _____

REASON FOR ADMINISTERING: _____

DIAGNOSIS: _____

POSSIBLE SIDE EFFECTS: _____

PHYSICIAN SIGNATURE:_____ DATE:_____

PHYSICIAN PHONE NUMBER:_____ FAX#:_____

Parent/Legal Guardian Section

My child is to receive the above medication, according to the physician's direction. I give my permission for this medication to be administered to my child. I agree that United Services will be indemnified and and held harmless of any wrongdoing regarding issuance of medication which I have requested to be given to my child.

The agency has my permission to call the physician with any questions regarding the above medication. I have provided the unexpired medication, in the original container. Medication not picked up within 5 days of the end of the school year or duration of the order, will be destroyed. For pre-school children, this consent expires at the end of the current school year. For child care children, the consent expires in one year.

ALLERGIES (medications, foods):_____

I need to pick up the medication each day: _____ yes _____ no

Parent/legal guardian signature: _____ Date:_____

Relationship to child:_____

RN Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____ 2008