



Authorization for Administration of Medication

Medication Type:

Prescription **Non**-Prescription Topical Ointment

I hereby authorize The Nursery at Our Lady of Sorrows to administer the following medication to my child:

Name: _____

- I understand that before The Nursery at Our Lady of Sorrows can administer medication of any kind they must have a signature and instructions from my child's physician.
- Authorizations for non-prescription medications and topical ointments (other than sunscreen/insect repellent) will be valid for 90 days.
- Duration of "as needed" medications require a written order from the child's physician and cannot exceed 90 days.

I further agree to indemnify and hold harmless The Nursery at Our Lady of Sorrows and their employees against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Parent/ Guardian Signature: _____

Information to be filled out by Physician:

Medication _____

Administration Route: _____

Possible Side Effects: _____

Dosage: _____

Times of Administration: _____

Start date ___/___/___ End date ___/___/___ (can not be longer than 90 days)

Physician's Name: _____

Physician's phone number: _____

Physician's Signature _____ Date: ___/___/___