

**Leaping Learners
37 Patillo Rd
Stockbridge, GA 30281**

Authorization to Dispense Medication

Child's Full Name _____

Name of Medication _____

Prescription Number _____

Physician's Name _____

Address _____ Telephone # _____

Date (s) to give medication: From _____ to _____

Time of Day medication is to be given _____ am or _____ pm

Amount of (Dosage) of medication to be given each time: _____

How medication is stored: _____

Parent/Guardian Signature _____ Date _____

For Center Use

If adverse reaction to medication was noted, please describe action taken:

Note: This form must be used for all over the counter medications (Tylenol, cough syrup, Benadryl, etc.) and all prescription medications including the use of Nebulizer.

Parent/Guardian Signature _____