AUTHORIZATION TO ADMINISTER BENADRYL/EPIPEN

To _____
Child's Name

For prescribing physician to complete:

Administer **Benadryl** by way of _____in the amount of _____ at _____ for _____
Route Dosage Time # of days.

for _____(may include hives, itchy skin, irritated eyes and insect bites).
Reason or Symptoms for medication

Possible side effects include : _____.

Administer **Epipen** by way of _____in the amount of _____ at _____ for _____
Route Dosage Time # of days.

for _____(may include hives over entire body, wheezing, difficulty swallowing, swelling, & vomiting).
Reason or Symptoms for medication

Possible side effects include : _____.

Physician's Name & Address:

_____ Physician's Signature: _____

_____ Phone:_____ Date:_____

_____

* * * * * * * * * * * * * * *

I, _____ (parent or guardian) authorize Little Lights Christian Early Learning Center to administer the above prescription or over-the-counter medication as directed above. The medicine will be brought to school in the original container with the prescription label attached which includes the name of the physician, the name of the medicine, the dosage, the child's name and the date. It must be a current prescription.

_____ _____
Parent Signature Date

* * * * * * *

Record of medication administered:

Date	Time	Amount	By Whom
_____	_____	_____	_____
_____	_____	_____	_____

Info provided to:

Little Lights ph: 720-872-2200
Christian Early Learning Center
15150 Washington St
Thornton CO 80023