FAITH LUTHERAN PRESCHOOL

4010 Williams Drive, Georgetown, Texas 78628
512-863-2634
acummings@flcms.org www.flpreschool.com

FAITH LUTHERAN PRESCHOOL
ALLERGY AND MEDICATION FORM

Child's Name:	**Date:**

Allergies: List any known **allergens:** *Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (IE. Anaphylactic shock).*

Allergy Symptoms: *Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.*

Allergy Procedures: *Please indicate all the steps necessary and the order in which they should be taken.* **If your child's physician prescribes medication such as an EPI pen, a Medication Authorization and Procedure Form from the physician must accompany this form along with the medication to be kept in the Preschool Office (see attached form).**

List any **medical conditions** under a doctor's treatment: *(including medical, physical, mental, behavioral, or development)*

List any **prescribed medications** for the child (whether given at school or not):

I have provided all pertinent information for my child regarding allergies, medications, and medical conditions.

X_____ _____
Parent's Signature Date

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FAITH LUTHERAN PRESCHOOL
MEDICATION PROCEDURE FORM

If your child's physician prescribes a medication that your child would need in the event of acute illness or allergic reaction, such as an EPI pen, this form must be completed.

Medication that will be given to a child while they are on campus must be kept in the First Aid Box located in the Preschool Office; there are NO EXCEPTIONS' TO THIS RULE.

Name of Child to Receive Medicine:	**Name of Medication:**	
Prescribing Physician:	**Prescription No.**	**Expiration Date:**

Dosage	**Time to be Given**	**Continue Medication Until (date)**

List procedures employees should follow in order (use reverse side if needed):

I have provided all pertinent information for my child regarding allergies, medications, and medical conditions.

X_____ _____
Parent's Signature Date

Date and Time Medication was Administered: (used only if administered)