The Montessori Elementary & Middle School

Authorization for **Prescription** Medication

(Please complete *every* item on this form)

Student's Name: _____

All subsequent guidelines must be followed in order for the medication to be given to the student.

- MEDICATION **MUST** BE IN ITS ORIGINAL CONTAINER.
- THE PRESCRIPTION MEDICATION **MUST** INCLUDE THE PHARMACY LABEL THAT HAS THE CHILD'S NAME, TYPE OF MEDICATION, THE DOSE, THE SCHEDULE FOR ADMINISTERING, THE PHYSICIAN'S NAME AND THE DATE. (If you do not have the original container, you can go to your pharmacy and ask them for a duplicate label for that particular prescription.)

MEDICATION ADMINISTRATION INSTRUCTIONS:

1. Name of medication_____Dosage_____
2. Time of administration _____
3. This student is expected to be receiving this medication (how long?)_____
4. Special instructions regarding this medication_____
   _____

PARENT/GUARDIAN STATEMENT

1. I/We, the undersigned parent(s)/guardian(s) of _____, request that a school employee assist, or be present, with the self-administration of the above medication according to the physician's instructions. I/We agree to furnish the necessary prescribed medicine in the properly labeled container, to provide replacement medication as necessary, and I/we agree to notify the school immediately if the physician or medication prescription is changed.

Parent/Guardian Signature _____Date_____

Home Phone_____ Work Phone_____ Cell Phone_____