



www.montessoricc.org

PHYSICIAN'S MEDICATION AUTHORIZATION FORM

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____ during center hours and that this medication may be administered by center staff.

Prescription: Medication: _____

Dosage and Time: _____

Duration: _____

Date of Prescription: _____

Signature of Physician: _____

Date: _____

------(this portion to be completed and signed by parent/guardian)-----

I, _____, the parent and/or guardian of _____, request that center staff administer the medication prescribed above to my child during center hours. I understand that the person who will administer the medication may be inexperienced. I also agree to furnish said medication in the container supplied by the drug store with the label intact.

Signature of Parent: _____

Date: _____