MONTESSORI CHILDREN'S CENTER

www.montessoricc.org

MEDICATION AUTHORIZATION FORM

LONG TERM 10 DAYS OR MORE/MUST BE AUTHORIZED BY PHYSICIAN

Prescription and non-prescription drugs, including vitamins and aspirin, will be given to a child ONLY with the parent's or guardian's COMPLETED written consent.

Child's Name_____ Date of Birth _____

Child's known allergies_____

Montessori Children's Center has my permission to administer the following medication:

Medication and prescription Number:_____

Dosage:_____ Times to be given:_____ Route of Administration:_____

Special Instructions:_____

Reason why child is taking this medicine_____

Any known adverse reaction or side effects to this medicine_____

_____

This authorization is effective from_____ to _____

Parent's or Guardian's Signature_____ Date of Authorization_____

Date	Time	Medicine Dosage	Staff	Adverse Reaction and/or Errors	Parents Notified Yes/No	"As needed medication" Symptoms exhibited	Parents Notified Yes/No

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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:_____

For as needed medicine please identify symptoms that will necessitate administration of as needed medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

_____

Date of prescription:_____

Possible side effects:_____

_____ _____ _____

Physician's Name | Physician's Signature | Date

I,_____, the parent 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 or Guardian) Date