Authorization For Administration Of Prescription Medication

STUDENT'S NAME:		BIRTH DATE:	
HOME TELEPHONE:		TEACHER(s):	
SCHOOL:		CLASS:	
EMERGENCY CONTACT PERSON:		EMERGENCY CONTACT PHONE	

REQUEST AND APPROVAL OF PARENT / GUARDIAN

I hereby request and give permission for the following medication prescribed herein to be administered to my child who is named above for the duration indicated by the Physician. I will provide the medication in the original container.

NOTE:
IT IS THE PARENT'S / GUARDIAN'S RESPONSIBILITY TO NOTIFY THE SCHOOL OF ANY CHANGES IN THE PRESCRIBED MEDICATION OR IN THE ADMINISTRATION OF THAT MEDICATION. THIS AUTHORIZATION WILL EXPIRE ON THE DATE INDICATED BY THE PHYSICIAN OR ON JUNE 30TH OF EACH SHOOL YEAR. THE SCHOOL CANNOT AND WILL NOT ADMINISTER ANY PRESCRIPTION MEDICATION WITHOUT THE AUTHORIZATION OF A PARENT.

I release Montessori Academy of London, its employees and agents from any liability for loss, damage or injury, howsoever caused, to my child's person or property arising out of administering, or failure to administer the procedure as provided herein.

Parent's / Guardian's Signature

Date Signed

STATEMENT OF PHYSICIAN

NAME / TYPE OF PRESCRIPTION MEDICINE	
DOSAGE / AMOUNT TO BE GIVEN	
FREQUENCY / TIMES FOR ADMINISTRATION	
INSTRUCTIONS FOR ADMINISTRATION	
DURATION	
ANTICIPATED REACTION TO MEDICATION / SYMPTOMS, SIDE EFFECTS	

Parent's Name (please print)

Parent's Signature

Date: