Montessori Mes Petits Academy (2010)
Care & Education

Medication Authorization Form

Date:_____

I hereby give my permission to the staff of Montessori Mes Petits Academy to administer _____

(Name of Medication and Prescription Number or over the counter's Medication)

to my child _____ according to the Doctor's orders and instructions.(This will be on the vial or bottle for prescription drugs).

_____

Signature of Parent of Guardian

Medication Record

Name of Child _____ **Physician** _____

Name of Medication _____

Date Commenced _____ _____ _____ **Date Stopped** _____ _____ _____
D M Y D M Y

Time _____ **Dosage** _____

Additional Comments (Possible Reactions, Consequences of Missing Medication

_____

NOTE One form for each prescription or refill is needed. Completed form goes into the child's file.

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