PERMISSION FOR ADMINISTRATION OF MEDICATION

In the event your child needs to receive prescribed medication during the school day, please complete the following information and submit with your doctor's note or signature below. All medications must be in the original container and include dosage instructions. Please deliver all medications, instructions and permission forms to the school office. For safety reasons, do not send medications of any kind in your child's lunchbox or backpack.

DATE: _____

STUDENT'S NAME: _____

TEACHER: _____

I give my permission for the staff of the California Montessori Project to administer the following medication to my child. **A doctor's signature below must accompany all prescription medication.**

Begin Date of Medication:	**End Date of Medication:**
Type of Medication:	**Refrigerate:** ☐ Yes ☐ No
Rx# :	**Dosage:**
Time of Administration:	**Medication Expiration Date:**
Parent Signature:	
Physician Signature (or attach doctor's note):	

Administration of Medication				
Date	Time	Medication	Dose	Staff Signature