Montessori School of Anderson

Permission for School Administration of Non-Prescription Medication

Healthy Children Learn Better

For school use only:
□ Routine
□ PRN (As needed)
Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

Student's Name	Grade	Date of Birth	Homeroom Teacher
_____	_____	_____	_____

Name of medication to be given at school:	Dosage:
Reason for Medication:	Route:
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any special storage requirements: □ None □ Refrigerate □ Other (please specify):
Anticipated number of days medication will be given at school: □ until end of current school year □ ____ weeks □ ____ days	Is child allergic to any food, medicines, or other items? □ No □ Yes (List allergies.)
Does your child take any other medications at home or at school? □ No □ Yes (If yes, what are the medications?)	

Stamp, Print or Type Health Care Provider's Name & Address:	Office Phone Number:
	Office Fax Number:

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if any of my child's medications change.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print or Type Name of Parent / Guardian Day Phone Number