The Duluth Montessori School

Medication Dispensing Permission Form

Child's Name:_____

Teacher:_____

Name of Medication to be taken:_____

Prescription Number:_____

Time Medication is to be given _____
(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given:_____

Dates to be given:_____
(Not to exceed two weeks without a physician's statement)

Does the medication require refrigeration? Yes ☐ No ☐

_____ _____
Parent's Signature Date

Phone number where I can be reached: _____

FOR SCHOOL USE: (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping, etc.)

DATE	TIME GIVEN	AMOUNT	ANY ADVERSE REACTIONS	GIVEN BY
1._____	_____	_____	_____	_____
1._____	_____	_____	_____	_____
1._____	_____	_____	_____	_____
1._____	_____	_____	_____	_____
1._____	_____	_____	_____	_____

If noticeable adverse reaction to medication, what action was taken? Describe:

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in its entirety before the School can dispense any medication.