



# Creative Montessori Academy

## Permission to Administer Medication

This form must be completed and signed by the doctor before any medication may be administered to the student. No exceptions will be made.

Students Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

I hereby request that my child be administered his/her prescribed medication by Creative Montessori Academy personnel. I understand that the medication will be administered per the physician's order. I will notify the school of any changes or discontinuation of this medication in writing.

Parent/Guardian Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

PHYSICIAN'S DIRECTIONS TO BE COMPLETED BY THE PHYSICIAN ONLY	
Begin Administering Medication Date: _____ End Administering Medication Date: _____	
1. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
2. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
3. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
Physician Signature: _____	Date: _____

I \_\_\_\_\_ do not hold Creative Montessori Academy, Creative  
(Print Parent/Guardian Full Name)  
Montessori Academy employees, and/or Choice Schools and Choice School employees responsible for accidentally forgetting to administer any medication as prescribed by physician to my child \_\_\_\_\_.  
(Print Child's Name)

I understand that Creative Montessori employees may forget and I acknowledge, understand, and I am willing to accept and give permission to \_\_\_\_\_ who will be administering  
(Print Teacher's / Teacher Assistant's Name)

said medication to my child, as prescribed by the physician. If I want to ensure that my child received the medication, I have the right to come in to the school and administer this medication to my child.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

