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 mediation to my child.

Parent/Guardian Signature: _____

Date: _____

Creative Montessori Academy

Administering Medication Log

Administers Name: _____

Student's Name: _____

Type of Medication	Date	Time	Initials