WACO MONTESSORI SCHOOL
Authorization for Dispensing Medication

I authorize the staff of Waco Montessori School or accompanying medical personnel to give:

Child's Name: _____ DOB: _____

Name of medication: _____

Prescribing Physician: _____ Prescription #:_____

Dosage: _____ When to give: _____

Continue medication until (date): _____

NOTE: Medication must be in its original container and labeled with your child's name. Medication can only be administered in amounts according to the label directions.

Please check the appropriate boxes:

☐ Medication needs to be refrigerated
☐ Medication needs to be sent home each day
☐ Medication can be left at school until the last day inclusive

Parent's Signature: _____ Date: _____

Disposition of Left-Over Medication: ☐ Returned to Child's Parent ☐ none left Date: _____

This form will be retained in the child's permanent file.

Medication	Date	Time	Amount	Staff Name

August 2017

WACO MONTESSORI SCHOOL

Authorization for Dispensing Medication

Child's Name:

Medication	Date	Time	Amount	Staff Name