

MONTESSORI SCHOOL OF RALEIGH MEDICATION ADMINISTRATION FORM

TO BE COMPLETED AND SIGNED EACH YEAR BY PHYSICIAN/DESIGNEE AND PARENT

NON-PRESCRIPTION MEDICATIONS

Absolutely no Medication (non-prescription (over the counter) or prescription) will be administered by either school personnel or self (student) without the written authorization of a physician/designee and parent. Dosages for all medication will be administered according to directions indicated by physician or manufacturer's recommendation on the original label. A new form is necessary if there are any changes or additions. All Medication must be provided by parent.

This form will also be the authorization form used for off campus activities, including overnight trips.

Child's Name: _____ Classroom: _____

Drug Allergies (if none, state none) _____

Reason for Medication: _____

Name of Medication: _____

Physician/Nurse Practitioner/Physician Assist. Signature: _____ Date _____

Parent/Guardian Signature: _____ Date _____

PRESCRIPTION MEDICATIONS

I request that my child be administered the prescription medication (via school personnel or self) as indicated in the physician's order below.

Parent Guardian Signature: _____ Date _____

To be completed by physician/nurse practitioner:

Please list any prescription medication, which would need administering during school or school related activities, including overnight trips. (whether administered by school personnel or self (student). Please complete a separate form for additional prescription medications or provide a written physician's order.

Name and Form of medication Dosage Route:

Time to be given: Frequency

Side effects: _____

Continue in effect until (date or end of school year): _____

Physician/Nurse Practitioner/Physician Assistant Signature Date:

Physician's address/Phone Number _____

Student may self administer medications listed on form: Yes: _____ No: _____

To be completed by the School

Date Received: _____ Received By: _____