MONTESSORI OF ALAMEDA

MEDICATION AUTHORIZATION

Child's Name: _____

Medication: _____

Prescription ☐ Non-Prescription ☐ Refrigeration Required: YES ☐ NO ☐

If prescription, prescriber's name: _____ Tel: _____

Dosage Amount: _____

Time to Administer: _____ a.m _____ p.m _____ times/day

Dates for Administration: From _____ to _____

Date Date

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications: _____

_____

I give permission to administer medication to my child as stated above.

_____ _____

Signature Date

MOA STAFF COMPLETE THIS SECTION				
Date Administered	Time Administered	Amount of Medication Administered	Comments/Reactions	Staff Initials

This information is confidential and may not be shared or released without the parent's written permission.