MONTESSORI ACADEMY
EDISON LAKES

The Montessori Academy
Authorization & Permission for
Administration of Medication
This form is required for each medication administered

Student's Name _____
Last First Middle

Date of Birth_____ **Allergies**_____

School medications and health care services are administered following these guidelines:

- Physician/Prescriber signed dated authorization to administer the medication.
- Parent signed, dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.

Physician Authorization:

_____ _____
Medication/Health Care Treatment Dosage

_____ _____
Date Medication Prescribed Date to Discontinue/Re-evaluate/Follow-Up (circle one)

_____
Prescriber Name

_____ _____
Prescriber's Address Prescriber's Emergency Phone Number

_____ _____
Intended effect of this medication Expected side effects, if any

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize The Montessori Academy and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child) to self-administer lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against The Montessori Academy, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify The Montessori Academy, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of administration of said medication.

_____ _____
Parent's Name Parent's Emergency Number

_____ _____
Parent Signature Date signed

Medication Log

Date	Time	Dosage	School Official Administering Medication