Children's House Montessori School

Medication Authorization Form

For Prescription and Non-prescription Medications

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medications** (those lasting longer than 10 school days) except over the counter topical products.

Section A: To be completed by parent/guardian for ALL medication authorizations

Child's name: _____ Date of Birth: _____

Children's House Montessori School has my permission to administer the following medication:

Medication Name (including strength):_____

Dosage: _____ Time to be administered: _____

Route of administration (Oral, Topical, Inhaled, Patch, Eye, Ear, Auto-Inject Device) _____

Special Instructions: _____

Reason for medication:_____

Possible side effects:_____

Known allergies: _____

Symptoms for "as needed":_____

This authorization is effective from _____ until _____
(Start date) **(If more than 10 school days, physicians authorization required)**
(Exception: over the counter topical products can be authorized for a full year without physicians permission)

Parent's or Guardian's Signature: _____ **Date:** _____

If discontinued before end date, I authorize discontinuation on:_____

Parent's or Guardian's Signature: _____

Section B: To be completed by child's physician for long-term medication authorizations only

I, _____ certify that it is medically necessary for the medication listed
(Name of Physician)

below to be administered to: _____ for a duration that *exceeds 10 work days*.
(Child's name)

Medication Name: _____

Dosage: _____ Time to be administered: _____

Route of administration (Oral, Topical, Inhaled, Patch, Eye, Ear, Auto-Inject Device) _____

Special Instructions: _____

_____

Known allergies: _____

This authorization is effective from _____ until _____
(Start date) **(End date no longer than one year)**

Physician's Signature: _____ **Date:** _____