MEDICATION AUTHORIZATION

Short -Term Medication Authorization (Prescription or Non-Prescription)

Child's First and Last Name:	Date of Birth: / /	Sex: □ M □ F

The Learning Village Montessori has my permission to administer the following medication:

Medication Name and/or Prescription Number (including strength):
_____

Dosage to be Administered: _____ Time(s) to be Administered: _____

Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and when possible, measurable parameters):
_____

Possible Side Effects: _____
(Parents must supply package insert or pharmacy printout for complete list of possible side effects)

Special Instruction (if any): _____
_____

This authorization is effective from: _____ to _____ (not to exceed 10 working days, unless otherwise prescribed below by the child's physician).

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

Medication Information

- Medication must be presented in the original container, and prescription medication must be clearly labeled with the full pharmacy label. Medication should bear the child's full name, medication name, and time, dosage, and number of days to be administered.
- Medication (prescription or non-prescription) that is to be administered longer than 10 working days requires written authorization from the child's physician **and** parent/guardian.
- All medication must be picked up within 14 days of the authorization expiration date.
  The school will dispose of any medication that is not picked up by the parents within 14 days.

Long-Term Medication Authorization (Prescription or Non-Prescription)

I certify that it is medically necessary for the medication(s) listed below to be administered to:
_____ during school hours, for a duration that exceeds 10 work days.

Medication Name and/or Prescription Number (including strength):
_____

Dosage to be Administered: _____ Time(s) to be Administered: _____

This authorization is effective from : _____ to _____.

Special Instruction (if any): _____
_____

Name of Physician: _____ Date: _____

Physician's Signature: _____ Phone: _____