HAMILTON MONTESSORI SCHOOL
EDUCATION FOR PEACE

MEDICATION AUTHORIZATION FORM

I_____ authorize the administration:
Parent's Name (Please Print)

of: _____
Medication (please print)

to: _____
Child's name (please print)

By Hamilton Montessori Staff member

Start Date: _____ End Date: _____

Use the following Instructions:

Dosage: _____ Time(s) of Administration: _____
(as prescribed by doctor) (as prescribed by doctor)

Storage instructions: _____

Stop medication immediately if the following is observed:

_____
_____

_____ _____
Date: Parent's Signature

_____
Staff Signature

DRUGS AND MEDICATIONS ADMINSTRATION RECORD FOR: _____

Date	Time Given	Amt. Given	Staff Signature	Comments of Observations

Changes noted with regards to Medication administration: (to be signed by parent)

_____
_____

Parent Signature: Date: