



Montessori Mes Petits Academy (2010)
Care & Education

Medication Authorization Form

Date: _____

I hereby give my permission to the staff of Montessori Mes Petits Academy to administer _____

(Name of Medication and Prescription Number or over the counter's Medication)

to my child _____ according to the Doctor's orders

and instructions. (This will be on the vial or bottle for prescription drugs).

Signature of Parent of Guardian

Medication Record

Name of Child _____ Physician _____

Name of Medication _____

Date Commenced _____ Date Stopped _____

Time D M Y Dosage D M Y

Additional Comments (Possible Reactions, Consequences of Missing Medication)

NOTE One form for each prescription or refill is needed. Completed form goes into the child's file.

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