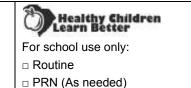


## **Montessori School of Anderson**

## Permission for School Administration of Non-Prescription Medication



Start Date: \_

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

complete a separate form for each child.						
Student's Name		Grade	_   _	Pate of Birth	Homeroom Teacher	
Name of medication to be given at school:			Dosage:			
Reason for Medication:		R	Route:			
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any special storage requirements:  □ None □ Refrigerate □ Other (please specify):					
Anticipated number of days medication will be given at school:  until end of current school year  weeks  days	Is child allergic to any food, medicines, or other items?  □ No □ Yes (List allergies.)					
Does your child take any other medications at h	ome or at school?	□ No □ Yes (If yes	, what are th	ne medications?)		
Stamp, Print or Type Health Care Provider's Name & Address:				Office Phone Number:		
				Office Fax Number:		
I give permission for my child,above medication as prescribed. I give permiss to discuss this medication and my child's health provide information about this medication and n require that I agree to the school district's rules responsible for notifying the school if any of my	. I give permission ny child's health to about medications	for the health care the school nurse of before this medicin	provider na r school adr	med above or his ninistrator. I unde	s/her designated employees to erstand that the school may	
Signature of Parent / Guardian				Date		
Print or Type Name of Parent / Guardian				Day Phone Number		