Hope
MONTESSORI ACADEMY

PERMISSION FOR MEDICATION

Parent/Guardian

I hereby give my permission for Hope Montessori Academy to administer the following prescription or over the counter medication at the school facility as ordered by my child's physician. I understand that it is my responsibility to furnish the medication in its original container.

_____ Date_____
Signature of Parent or Guardian

Medication Authorization Order

Health Provider

Name of Child_____ Age_____

Primary Health Care Provider_____

Medication_____ Dosage_____ Route_____

Start Date:_____ End Date:_____

_____ Date_____
Signature of Person with Prescriptive Authority

Note: All medications must be brought to Hope in its original pharmacy container, appropriately labeled by the pharmacy, along with a copy of the medication authorization order.