California Montessori Project

PERMISSION FOR ADMINISTRATION OF MEDICATION

DATE: _____

STUDENT'S NAME: _____

TEACHER: _____

I give my permission for the staff of the California Montessori Project to administer the following medication to my child. **A doctor's signature below must accompany all prescription medication.**

Begin Date of Medication:	**End Date of Medication:**
Type of Medication:	**Refrigerate:** ☐ Yes ☐ No
Rx# :	**Dosage:**
Time of Administration:	**Medication Expiration Date:**
Parent Signature:	
Physician Signature:	

Administration of Medication				
Date	Time	Medication	Dose	Staff Signature