learning - how to live - together

Village Montessori School

AUTHORIZATION FOR MEDICATION

PLEASE PRINT

CHILD'S FULL NAME_____

NAME OF MEDICATION_____

PRESCRIPTION NUIMBER_____

TIME MEDICATION IS TO BE GIVEN_____

(Medication will not be given on an "As needed basis", specifics must be provided)

AMOUNT_____

DATES TO BE GIVEN _____

Parent signature date

Dosage ***Given by*** ***Date/Time*** ***Reaction***

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