PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AUTHORIZATION/ADMINISTRATION FORM

TO BE COMPLETED BY PARENT

Today's Date:_____

By signing below, I give permission for Radiant Montessori to give _____
(Child's Full Name)

_____ the following medication:
(Child's Date of Birth)

Medication:_____

Dose: _____ Time/frequency of dose:_____

Route of administration: ☐ Oral ☐ Rectal ☐ Topical ☐ Inhaled ☐ Eye ☐ Nose ☐ Ear

☐ Other:_____

Start Date:_____ End Date:_____

Reason for Medication:_____

Possible Side Effects:_____

Special Handling or storage instructions:_____ Refrigerated: ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date:_____

Physician/Nurse Practitioner's Signature: _____ Date:_____

Only for over-the-counter medication requiring medical consent, otherwise the pharmacy label indicates physician's permission. ***If the dosage is not listed for a specific age or is different than listed*** *on the medication container, a doctor's authorization in writing or a signature above is required.*

Note form Physician/Nurse Practitioner's Signature? ☐ Yes ☐ No

TO BE COMPLETED BY STAFF

Is the parent portion of this form complete?	☐ Yes ☐ No
Is the medication in its original child proof container?	☐ Yes ☐ No
Is the original prescription label on the medication container?	☐ Yes ☐ No
Is the child's first and last name on the container? (siblings cannot share)	☐ Yes ☐ No
Is today's date before the expiration date on the medication container?	☐ Yes ☐ No

Was there any unused medication?	☐ Yes ☐ No
Was the unused medication returned to the parent?	☐ Yes ☐ No
If not returned, was the unused medication disposed of properly?	☐ Yes ☐ No

Medication Returned to:_____

Date Returned:_____ Returned By:_____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AUTHORIZATION/ADMINISTRATION FORM

Child's First and Last Name:_____

Medication:_____ Dosage:_____

Dose	Date	Time	Given By (Staff Initials)	Comments

Teacher's Name:_____ Initials:_____

Teacher's Name:_____ Initials:_____

Teacher's Name:_____ Initials:_____