Montessori
SCHOOL *of* HUNTSVILLE
SINCE 1965

MEDICAL PRACTITIONER AUTHORIZATION TO ADMINISTER MEDICATION

Date_____

Child's Name_____DOB_____

Parent's/Guardian's name(s)_____

Address_____
Street City Zip

Home phone_____Parent's contact number_____

Physician, Nurse Practioner, or Physician Assistant Name_____

Address_____Phone_____
Street City Zip

Name of Medication_____

Type_____Dosage_____
tablet, liquid, etc. tsp., puffs, etc.

Exact time(s) to be administered _____

Possible side effects_____

Types of illness_____

Medical Practitioner's signature_____**Date**_____

I hereby permit the staff of the Montessori School of Huntsville to administer to my child the above named medication, in the dosage and at the time(s) indicated.

Parent's signature_____**Date**_____