STARWOOD
Montessori School

WEEKLY MEDICATION AUTHORIZATION

CLASS: _____ CHILD NAME: _____

PLEASE CIRCLE: YES NO Is your child able to go outside?
YES NO Is the medicine clearly labeled with your child's name?
YES NO Does this medication need to be refrigerated?

INSTRUCTIONS: Name of Medicine: _____
_____
Dosage: _____

Week Beginning: Month _____ Day _____

Circle Day(s) To Be Given: Monday Tuesday Wednesday Thursday Friday
Circle Time(s) To Be Given: 12:00 (noon) 4:00pm

Please Note:

Starwood Montessori School and its staff are not responsible for any side effects, complications or even any fatality arising as a result of administering medicine as noted by you in the instructions.

***No eye, ear or nose drops will be administered.**
***Parents are responsible for picking up medication at the end of each day.**
***No narcotics.**

Parent's Signature: _____ Date: _____

(Medicine will only be administered if in its original bottle and not expired.)
(NEW FORMS MUST BE FILLED OF EACH WEEK.)

The following is for staff use only.

12:00 (noon)	**Name of Med**					
	Amount					
	Staff Full Signature					
4:00pm	**Name of Med**					
	Amount					
	Staff Full Signature					

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