PORTAGE MONTESSORI SCHOOL
Department of Pupil Services
Health Services

MEDICATION AUTHORIZATION

To Parent or Guardian:

To comply with your request to administer medication to your child, you must agree to the following:

1. Your written permission must be on file at the school office.
2. You are responsible for the safe delivery of the medication in the original container to the school.
3. You agree to notify the school immediately if there is a change in the use of the medication.
4. You understand that we must have written directions from your physician.
5. Liquid medication shall be the responsibility of the parent and will be administered only at the principal's discretion.
6. You release the Board of Education and its employees from any and all liability for damages or injury resulting directly or indirectly from this authorization.
7. You also give permission to school personnel to contact the physician with questions regarding the medication order and to send progress report or to clarify information.

PARENT'S AUTHORIZATION TO GIVE MEDICATION

Student Name_____dob_____Teacher_____

I have read and understand the above agreement.

I hereby request and give my permission for a Portage Montessori staff member

to administer _____ of _____
(# of pills) (name of medication)

at _____as directed by Dr. _____ to my
(time)

child.

Parent/Guardian Signature_____

Address_____

Home Phone_____Work Phone_____

DATE:_____