Swannanoa Valley Montessori School

Request for Medication to be Given During School Hours
(prescription/nonprescription medication)

Student's Name:_________________________________DOB:______________
School:_______________________ Medication:__________________________
Dosage:_______________________ Route:______________________________
Time medication to be given: AM ________ PM ________
Please circle: Before After With Meals As Needed
Reason medication is prescribed: ______________________________________
Start Date: ____________ Stop Date: _____________
Significant information (include side effects, toxic reactions, omission reactions):
____
____
Contraindications:____

____ ____________________
Signature of Licensed Health Care Provider **Date**

I hereby give permission for my child,________________________ to receive medication during school hours. As the parent/guardian, I assume the responsibility of any adverse reactions this medicine may cause for my child. I agree to send the prescribed medicine in a container properly labeled by a pharmacist. Nonprescription medicine will be sent in the original container.

____ ____________________
Signature of Parent or Guardian **Date**

____
Home telephone number

____
Work telephone number

____
Emergency telephone number