MAY SANDS MONTESSORI SCHOOL

A public school of choice

1400 United Street #110, Key West, Florida 33040

Authorization for Medication

Name of Student____

Treatment plan (to be completed by physician)

Date_________________ Physician___________________________________

Physician Address___________________________________ Physician phone________________

Diagnosis____

Medication & Dosage____

Side Effects____

Purpose of Medication____

Student Allergies____

Directions for Administration by School Personnel______________________________________

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Physician Signature_______________________________

Permission (To be completed by Parent or Guardian)

Date______________________

My permission is hereby granted to the School Principal or her specified delegated personnel to administer prescribed medication to my _______________________.

Relationship

Student's Name________________________

Signature of Parent/Guardian____