THE Sullivan MONTESSORI SCHOOL
Medication Authorization

Child's Name: _____ Date: _____

I, the parent or caregiver of the above child, hereby grant permission to the teachers and staff of Sullivan Montessori School to dispense medication provide by me:

Medication: _____

Dosage: _____

Storage requirements: _____

Other instructions: _____

The medication provided is:

☐ Over-the-counter medication in its original container with all related instructions enclosed.

☐ Prescription medication in its original container with prescript tion label affixed, and instructions for use provided.

Signature: _____ Date: _____

Medication log (for staff use only)

Name Dose Date/Time By Whom/Comments

Name	Dose	Date/Time	By Whom/Comments