



MONTESSORI  
CHILDREN'S  
HOUSE OF  
DURHAM

## Permission to Administer Medicine

Child's Name \_\_\_\_\_

Physician's Name \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Other Instructions (e.g. how to use an inhaler) \_\_\_\_\_

Special conditions? (Refrigerate, take with liquids, shake well, etc.)

Time(s) to be given \_\_\_\_\_

Dates to be given \_\_\_\_\_

Does the medicine need to go to Little House ? (circle one)      YES      NO

Best Number to call for clarification \_\_\_\_\_

Parent's Signature \_\_\_\_\_      Date \_\_\_\_\_

### Medicine Administration Record to be completed by Staff

Name of Medicine	Dosage	Time Given	Date	Initials	NOTES:

For staff use only: Fill out original AND copy of form, and give *copy* to parent each day. Original form filed in student file at the end of the week.