Philomath Montessori School

PO Box 125 • Philomath, OR 97370 • (541) 929-2672

MEDICATION PERMISSION SHEET

Child's Name _____

Name of Medication _____

Condition for which prescribed: _____

Possible Side Effects: _____

Instructions:

Dosage amount _____ Begin Date _____ End Date _____

Times of Day to be Administered: _____

Date: _____ Signature: _____
(parent)

If prescription medicine:

Date: _____ Signature: _____
(physician)

STAFF: Fill in date, time, and initials whenever dispensing medicine. Place in child's folder when medication is complete**.**

Monday	Tuesday	Wednesday	Thursday

Disposition of Medicine: Returned to Parents: _____Date: _____
Disposed of: _____Date: _____