CLEMSON MONTESSORI SCHOOL, INC.

PERMISSION TO ADMINISTER MEDICATION

IMPORTANT: FILL OUT COMPLETELY AND LEGIBLY

We Will Not Accept "As Need" Instructions. Please Be Specific.

CHILD'S NAME _____ **DATE** _____

MEDICATION AND DOSAGE

_____**TIME**_____

_____**TIME**_____

TIME MEDICATION LAST ADMINISTERED *(IMPORTANT)*_____

ANY POSSIBLE SIDE EFFECTS_____

_____

SIGNATURE OF PARENT/GUARDIAN

----------**STAFF USE ONLY**----------

MEDICATION ADMINISTERED

BY_____**TIME**_____

_____**TIME**_____

COMMENTS_____

RETURN THIS PORTION TO PARENT/GUARDIAN

CHILD'S NAME_____**DATE**_____

MEDICATION & DOSAGE:

_____

ADMINISTERED:

BY _____**TIME**_____

COMMENTS _____