

REQUEST TO GIVE MEDICATION

PLEASE NOTE: ALL MEDICATION MUST BE IN ORIGINAL CONTAINERS WITH CHILD'S NAME, PHYSICIAN'S NAME AND DIRECTIONS FOR USE AND DATE CLEARLY VISIBLE.

I request that	at my child, _				
be given		medication			
on the follo	wing date(s):				
at the follow	ving time(s) o	f day:			
The dosage	to be given is	·			
Physician's	name:	Phone:			
PLEAS	E DO <u>not</u> p	UT MEDICATION IN CHILD'S LUNCH BOX OR BACKPACK!			
	ture of Parent/ Guardian Date				
******	******	*************************************			
	For I	Mountain View Montessori School Use Only			
MEDICAT	ION GIVEN:				
DATE	TIME	TEACHER ADMINISTERING MEDICATION			