The Discovery Montessori

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6553 Ninth Line Mississauga

PARENTS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

I authorize the administration of _____Prescription #_____
Name of Medication

Prescribed by:_____Phone No. _____
Name of the physician

To my child _____ by the Discovery Montessori Inc.
Child's Name

Start Date_____ End Date: _____
Day / Month/Year Day / Month/Year

Date of Purchase_____Expiry Date:_____
Day / Month/Year

INSTRUCTIONS FOR ADMINISTRATION OF MEDICATION.

Dosage_____

Time of Administration_____
Hours Minutes

Storage Conditions_____
Note: Only medications in their original container or package will be accepted.

STOP MEDICATION IF ANY OF THE FOLLOWING SYMPTOMS ARE OBSERVED

_____

_____

ANY OTHER DETAILS

_____

_____

I, the Parent (the "Undersigned"), hereby agree to release, indemnify and hold harmless The Discovery Montessori Inc., its agents, directors, owners, employees and contract staff from any and all claims, incidental, special or consequential damages and all other liabilities arising out of or in any way relating to the dispensing of the medication referred to on this form.

PARENTS/GUARDIAN NAME_____

SIGNATURE._____DATE:_____

SIGNATURE OF DIRECTRESS_____