Montessori School of Lemont
School Medication Authorization Form

To be completed every school year. Keep in the Executive Director's office.

Student's Name: _____

Date of Birth: _____ Grade:_____ Classroom: _____

Parent/Guardian Names: _____

Address: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

To be completed by the student's physician, physician assistant, or advanced practice RN:

Physician's Printed Name: _____

Physician's Office Address:_____

Office Phone: _____

Emergency Number of Physician/Medical Provider: _____

Medication Name: _____

Purpose: _____

Dosage: _____ Frequency:_____

Time medication is to be administered or under what circumstances: _____

_____

Route of Administration: _____

Prescription Date:_____ Order Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Expected side effects or intended effects school staff should be aware of, if any: _____

_____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

Physician's signature:_____ Date:_____

Self-administration of medication was taught to the student by the parent/guardian under the supervision of a physician, including return demonstration: ☐ YES ☐ NO