The McGuffey Montessori School

OFFICE USE ONLY

Medication / Supplement

REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION, FOOD SUPPLEMENT, FLUORIDE SUPPLEMENT OR MODIFIED DIET.
NOTE: A separate form must be completed for each medication.

Section I: Parent Request for Administration of Medication or Supplement
I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Student name _____ Age _____

Name of medication or supplement to be administered _____

Dosage _____ Time(s) of dosage _____

Signature of Parent/Guardian _____ Date _____

Section II: Physician's or Dentist's Instructions

Student name _____ is under my care and should receive

Name of medication or supplement _____

Dosage _____

Specific instructions for administration _____

Possible side effects _____

Physician/Dentist's name _____ Phone number _____

Signature of Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse/Dentist:

_____ Date _____

Send this completed form to TADS Admissions Management **Fax:** (612) 548-3326
Mail: TADS Admissions Management, 1201 Hawthorne Ave. Ste 100, Minneapolis, MN 55403

Section III: Log of Medication or Supplement Administered by Authorized Staff Member

Date and time of dosage	Amount of dosage	Signature of authorized staff member