



Medication Form 2007-08

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A separate form must be completed for each medication that must be administered at school.

Child's name: _____

Date of birth: _____ Weight: _____

Child's physician: _____ Physician's Phone Number: _____

Medications—prescription and over-the-counter—shall be administered to a child only with written consent of the parent or guardian. For any medication that must be maintained at the school for more than 10 school days, a physician signature is required.

Medication Name: _____

Dosage: _____

Administration Method: _____

Administration Time(s): _____

For as-needed dosing, describe symptoms that merit administration of this medication: _____

Describe possible adverse effects: _____

Additional Instructions: _____

I give permission for the staff of Odyssey Montessori to administer the above-named medications to my child as directed on the pharmacy label.

Parent/Guardian Signature: _____ Date: _____

The student named above needs to have medication administered during the school day for ongoing therapy or needs to have emergency medication on hand on an ongoing basis.

Physician Signature: _____ Date: _____

NOTE: All prescription medications must be in a pharmacy-labeled container that includes the students name, the name of the medication and the dosing requirements. All over-the-counter medication must be in an original box or container labeled with the child's name. Only the head of school may receive medications and medications forms. Both should be provided to the school by the child's parent or guardian.