Written Authorization Form For Prescription Medication

Section A: To be completed by child's parent/legal guardian

Medication authorization for ___________________________________ Date of Birth_____________

(Child's First/Last Name)

Known allergies ____

Reston Montessori School has my permission to administer the following medication:

Medication name_______________________________ Medication Expiration Date ________________

Parent/Legal Guardian's Signature_____________________________________ Date _______________

Section B: To be completed by child's physician (for medication that exceeds 10 work days)

Child's Name______________________________________ Medication_______________________

Dosage__________________________ Route of Administration______________________________

Times to be Administered____

Identify symptoms that will necessitate administration of medication______________________________

____

Special instructions (if any)____

Possible side effects____

Date Authorized______________________ Date to be Discontinued____________________________

(Cannot exceed 12 months from date authorized)

Physician's name _________________________________ Telephone number____________________

(Please Print)

Physician's Signature____

Section C: RMS OFFICE USE ONLY

Reston Montessori School ***Fairfax County, Virginia*** ***703-481-2922***

Prescription label affixed to medication? ☐ yes ☐ no Medication matches form? ☐ yes ☐ no

Approved MAT Designee Name____
(Please Print)

Approved MAT Designee Signature____

Date Authorization Received from Parent/Legal Guardian ___________________________________

PARENT REQUEST TO DISCONTINUE

I, parent/legal guardian, request to discontinue administration of the medication indicated on this consent form as of ______________________.
(Date)

Once the medication authorization has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

Parent/Legal Guardian's Name ______________________________________
(Please Print)

Parent/Legal Guardian's Signature _______________________________________

Approved MAT Designee Name_______________________________________

Approved MAT Designee Signature___________________________________

Date Medication Returned to Parent/Legal Guardian_____________________