Geist Montessori Academy

Student Medication Permit

Student Name _____ Date of Birth _____

Teacher/Grade_____ Date to be Initiated_____ School Year _____

Over The Counter Medications

Name of medication _____ Dosage_____

Reason for medication _____

Times to be administered/Frequency _____

Side effects to be expected _____

Over the counter medications must be in the original bottle with the label intact and student's name written clearly on the package.

I hereby give consent for the above-named student to take the over-the-counter medication as indicated.

Parent/Guardian Signature_____ Date_____

Prescription Medications

Name of medication _____ Dosage_____

Reason for medication _____

Times to be administered/Frequency _____

Side effects to be expected _____

I hereby give consent for the above-named student to take the prescribed medication at school, to be given as prescribed by the physician.

Parent/Guardian Signature_____ Date_____

The above-named student requires the prescribed medication at school, to be given only as directed on the original current prescription label on the container.

Physician Signature_____ Date _____

The prescription medication must be in the original prescription container with the original prescription label intact and current prescription attached to this form.

This form may be completed and faxed to (317)335-1265 attn: Nurse