Form 1b Casa Montessori School

Medication Information

Please fill out and return the following information on your child ***whether or not your child is taking any medication***. It is vital that we have an accurate record of ALL medication your child is taking, even if it is not administered at school. Please notify the classroom teacher immediately if there are any changes in this information.

Student's Name ______________________________ Date _________________

Is this child presently taking any medication? ___Yes ___No

If yes, please fill out the information below and have your doctor complete the Administration of Medication form on Form 2.

Type of Medication: ____

Date when started: ____

Reason: ____

Doctor's name prescribing medication: __________________________________

Does medication need to be administered at school? ___Yes ___No

Health Information

A Georgia Certificate of Immunization must be completed by your doctor and submitted to the school office no later than the first day of school.

Please list any medical problems of which we should be aware (i.e. diabetes, epilepsy, sight or hearing problems, bee sting allergies, etc.

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Name of student's physician _________________________

Physician's phone number _________________________

Form 2 Casa Montessori School
Administration of Medication

The following form should be completed by the physician prescribing medication for your child. It will be submitted to the administrative office for placement in your child's personal file. Please alert the school immediately if medication is changed in any way (type, dosage, time of administration, termination, etc.) ***Casa Montessori School and its staff will not be held liable for consequences of the administration of any medication as prescribed by the physician.***

Student's Name: ________________________Teacher: ______________________

Name of Medication: ____

Purpose of Medication: ____

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Physician's recommended dosage and method of administration: ____________

____

Physician's description of possible side effects and recommended action: _____

____

Should midday medication be administered on 12 noon dismissal days?
___Yes ___No

Termination date of administering medication: _____________________________

____________________________________ ____________________________
Physician's Signature Date

____________________________________ ____________________________
Parent's Signature Date

Office Use Only:
Approved By: _______________________ ___________________________
Administrative Personnel **Date**

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