



Authorization for Medication

I hereby authorize Mountain View Montessori School to administer the following medication to my child.

Name of Child _____

Medication _____

Dosage _____

Prescription _____ Non-Prescription* _____

A physician's note must be on file with the office for all non-prescription medications.

Dates in which medication is to be given. _____

Dates	Dosage	Time(s)	Staff Initials

Parent's Signature