The Duluth Montessori School

Medication Dispensing Permission Form

Child's Name: _____

Teacher: _____

Medication to be taken: _____

Does the medication require refrigeration? Yes ☐ No ☐

Schedule: _____ through _____
month/day/year month/day/year

Time of day: _____

Medication Dosage/Instructions: _____

_____

I give permission for a staff member of The Duluth Montessori School to dispense this medication to the child named above.

Parent/Guardian Signature: _____

Phone number where I can be reached: _____