

# MONTESSORI SHIR-HASHIRIM

Carlton Way and Berendo Campus

## Medication Consent Form

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Name/Type of Medicine \_\_\_\_\_ Date Prescribed: \_\_\_\_\_  
Date that last dose is to be given: \_\_\_\_\_

We accept medicine only if you can answer Yes to all the questions below.  
(Circle an answer for each one.)

Medicine consent form complete	Yes	No
Medicine in child-proof container	Yes	No
Medicine has original label	Yes	No
Child's name is on medicine	Yes	No
Label and parent's instruction match	Yes	No
Written instructions from the doctor	Yes	No

I give permission to Montessori Shir Hashirim to give the above-mentioned medicine to my child on the following dates and times:

Dates: \_\_\_\_\_ Times: \_\_\_\_\_

Side effects: \_\_\_\_\_

Name and Telephone Number of Doctor who prescribed the medicine:

Doctor's Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Name of Medicine	Dose	Date	Time	Given By	Comments

Parent/Guardian Print Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_