



# Montessori Elementary Charter School

1400 United Street, #110 Key West, Florida 33040

Telephone: 305.294.4910 Fax: 305.294.1404

By State law there is certain information we must have and certain guidelines that must be met in order for your child to receive medication at school. We are also held accountable by Monroe County School District to follow their guidelines, as indicated below. You can help in this endeavor by providing us with the most current information available. The medication permission form (on the reverse of this page) is to be delivered to the front office when your child needs to receive medication at school. Please read the important information below. This is a School District policy.

## Medication Permission Form

Please fill this form out completely, sign it and return it to the front office. The form must include your child's name, the name of the medication, dosage instructions, time to be administered, and the name of the physician who ordered the medication.

## Medication Container

The medication must be in the original and most current container you have received from the pharmacy. We cannot accept any container of medication that is old, outdated or in which new pills have been poured. If it is not the original, most current container issued by the pharmacist, we will not be able to give your child his/her medication during school hours.

If the directions on a prescription container of medication state "take as directed", a written, signed and dated set of instructions stating the exact dosage and time to be administered must accompany the medication. This information must only come from the prescribing physician.

## Over the Counter Medication

We cannot administer any "over the counter" medication, such as Tylenol, Ibuprofen cough or cold remedies unless it is accompanied by a written, signed and dated set of dosage instructions from the prescribing physician.

## Confidentiality

The student medication record is confidential; it may be shared only by initialing the line indicating with whom it can be shared.

## Safety

All medication will be kept in its original container and secured under lock & key.

## Unused Medication

Medication which is no longer prescribed for a student must be picked up by a parent/guardian within five (5) school days. Any medication not claimed within five (5) school days will be properly disposed of by the School Health Staff.



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## Authorization for Medication

Name of Student \_\_\_\_\_

### Treatment plan (to be completed by physician)

Date \_\_\_\_\_ Physician \_\_\_\_\_

Physician Address \_\_\_\_\_ Physician phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication & Dosage \_\_\_\_\_

Side Effects \_\_\_\_\_

Purpose of Medication \_\_\_\_\_

Student Allergies \_\_\_\_\_

Directions for Administration by School Personnel \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature \_\_\_\_\_

### Parental Permission (To be completed by Parent or guardian)

Date \_\_\_\_\_

My permission is hereby granted to the School Principal or her specified delegated personnel to administer prescribed medication to my \_\_\_\_\_.

Relationship

Student's Name \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_