Wilmington Montessori School

Medication Request

Child's Name: _____ Room: _____

Medication: _____ Dose: _____

Reason for administration: _____

Date(s) to be administered: _____ -OR- ☐ for the duration of the school year

Time: ☐ Lunchtime ☐ Other _____ (check with nurse)

This medication should be given: ☐ only if needed ☐ at the specified time

Child's allergies: _____

Important Notes:

You must supply a signed authorization from your child's health care provider for administration of any over-the-counter medication except the following (or their generic versions): *Motrin, Tylenol, Benadryl, Claritin, Halls cough drops, Mucinex, Sudafed, Bacitracin, benzocaine preparation, Caladryl, and hydrocortisone.*

Prescription medications do not need a separate health care provider authorization, but must be in the **original packaging with the pharmacy label attached.**

No cough or cold medicine will be given to children under 6 years of age.

I request that WMS administer the above medication to my child. I understand that medication should be in the **original packaging** (with **pharmacy label** if prescription) and clearly labeled with my child's name. If needed, as described above, I am **attaching authorization from my child's doctor** for administration of the medication.

Parent Signature: _____ Date: _____