The Springs
A Montessori School

Medication Authorization Form

Form adapted from the VDSS approved MAT Written Medical Consent Form

- Any changes to this authorization will require a new authorization.
- This form must be completed in English
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Short Term Medication (<10 days): Parents must complete for medication to be administered for 10 days or less.
- Long Term Medication (>10 days): The child's health care provider MUST complete this form for any Long-Term Medication, Emergency Medication, or when dosage directions state "consult a physician"

Child's Name: _____Date of Birth:_____

Child's Known Allergies: _____

The Springs Montessori School has my permission to administer the following medicine:

Medication Name: _____

Route of Administration (circle one): Oral Inhalants Topical Medicated Patches Eye Ear Auto-Injector

Other: _____ (may require additional training by parent or doctor)

Dosage: _____

Time to be Given (must be specific): _____

Emergency Medication: Only emergency medication can be given on an as needed (PRN) basis and (e.g., Epi-pen, Inhalers), requires the Physician's Authorization Below. Specific symptoms necessitating the administration of the medicine must be listed below (Additional care plans may be required):_____

_____

Possible side effects: _____

Special Instructions: _____

What action should THE SPRINGS take if side effects are noted (circle one):

Contact Parent Contact Prescriber Call 911 (automatic for EPI-PEN admin.) Other(describe): _____

This authorization is effective until: _____(The effective period must not exceed 10 work days, unless otherwise prescribed by the physician and must be a specific date.)

Parent or Guardian's Name (please print): _____

Parent or Guardian's Signature: _____ Date of Authorization: _____

Long Term Medication (LONGER THAN 10 DAYS)- REQUIRES PHYSCIAN'S AUTHORIZATION

I certify that, in my opinion, it is medically necessary that the medicine described below be administered to _____during facility hours and that this medicine may be administered by THE SPRINGS staff.

Medication Name: _____

Dosage and Times to be given: _____

This authorization is effective From: _____ Until: _____

For PRN medications, the following symptoms require the administration of the abovementioned medication: _____

Additional Instructions: _____

Name of Physician: _____ Phone: _____

Physician's Signature: _____ Date: _____

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Office Use Only

Facility Name: THE SPRINGS, A MONTESSORI SCHOOL Facility Telephone Number: 703-455-1000

Authorized child care provider's name (please print): _____

Authorized child care provider's signature: _____

Date Received from Parent:_____

AUTHORIZATION TO DISCONTINUE: Please verify with parent and obtain parent signature.

Date of Discontinuation:_____ Reason for Discontinuation: _____

I certify that my child no longer needs to receive this medication:_____

(Signature of parent or guardian)

Additional Notes: