GREAT WORK MONTESSORI

MEDICATION ADMINISTRATION PLAN

Student Name:__________________Class/Teacher:______________ Date of Birth:_____________

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and give my permission to the Great Work Montessori to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy/or physician labeled container that has the correct medication dosage identified for my student. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.)

Any prescription changes will require an additional signed and completed Medication Agreement.

Medicaid: Yes or No Medicaid Number:________________

Parent/Guardian Name:___________________________Phone:___________________________

Name of Medication:______________________ Dosage:_________________ Time:____________

Start Date:____________ End Date:_____________ Route:________________________________

Medication Purpose:____

I give my permission for the school staff to contact the prescribing physician regarding this medication.

Signature of Parent/Guardian __________________________________ Date________________

TO BE COMPLETED BY PHYSICIAN

Patient's Name:______________________________ Date of Birth __________________________

Name of Medication:______________________ Dosage:_________________ Time:____________

Start Date:____________ End Date:_____________ Route:________________________________

TIme(s) to be given at school: ____

Name of Physician:________________________ Office Phone Number:____________ Fax_______

Signature of Physician ____________________________________ Date___________________

Understanding: Only school employees who are trained and delegated by the a Registered Nurse Consultant may administer medication.

The employee administering the medication must document the time they gave the medication in the appropriate box and then initial in the appropriate box.

Name of Registered Nurse Consultant who trained and delegated: Bryan Maki (720-708-9705)

ATTACH SUPPLEMENTAL MEDICATION LOG