



**Damariscotta Montessori School**

93 Center Street ~ Nobleboro, Maine 04555  
Phone (207) 563-2168 ~ Email [dms@tidewater.net](mailto:dms@tidewater.net)

***Authorization for Dispensing Medication 2007-2008***

Child's Name \_\_\_\_\_

Parent Home Number: \_\_\_\_\_ Parent Work Number \_\_\_\_\_

I give the Damariscotta Montessori School staff permission to administer the following over the counter medications/remedies to my child. Please indicate in the space provided what kind of notification you'd like to receive. For example: call before medication is given, call after medication, only give if child has fever, or note any sensitivities to the remedies:

**Medication**

**Notification Needed, if any:**

<input type="checkbox"/> Children's Tylenol	
<input type="checkbox"/> Children's Advil (ibuprofen)	
<input type="checkbox"/> First Aid/Antibiotic Cream	
<input type="checkbox"/> Benadryl (allergic reaction to food/sting)	
<input type="checkbox"/> Sunscreen	

Notes/Comments:


\_\_\_\_\_  
Parent's Name (printed)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



Damariscotta Montessori School

*Authorization for Dispensing Prescription Medication 2007-2008*

Child's Name \_\_\_\_\_

Please fill out this form completely and make copies if you have more than one prescription medication for your child.

**Prescription Medication:**

Name of Medication		Prescription Number
Prescribing Physician	Physician Phone Number	Prescription Expiration Date
Dosage	When to Give:	

*Medication must be in its original container and labeled with your child's name and the date the medication is left at the school. Medication can only be administered in amounts according to the label directions.*

Special Notes on Child's Condition:

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Parent's Signature \_\_\_\_\_

Parent's Name (Printed) \_\_\_\_\_

Date \_\_\_\_\_

Date Medication was Returned to Parent	Date Medication was Returned to Parent