

**WEST SIDE MONTESSORI CENTER  
and  
OHIO DEPARTMENT OF EDUCATION**

**Request for the Administration of Medication or Treatment by an Authorized Staff Member**

A completed form must be on file before medication or treatment will be administered to a student during school/child care hours. A physician must authorize all medications as well as any prescribed treatments. A separate form must be completed for each medication or treatment.

**SECTION I (To be completed by the parent/guardian)**

The parent/guardian signing below requests and gives permission to a West Side Montessori Center staff member to administer medication/treatment as described below. The parent/guardian will personally deliver the medication to school and will pick up any unused medication. Medication not picked up by the start of the new school year will be discarded. The parent/guardian agrees to notify the school if the medication, dosage, or treatment procedure is changed or eliminated. The parent/guardian will not hold liable West Side Montessori Center for administering or failing to administer any medication or treatment.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

**SECTION II (To be completed by Physician or Dentist)**

(Name of Child) \_\_\_\_\_ is under my care and should receive

(Name of medication/treatment) \_\_\_\_\_

as follows: (Dosage) \_\_\_\_\_

Specific instructions: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Date medication/treatment is to begin: \_\_\_\_\_ End\*: \_\_\_\_\_

\*End date not to exceed the end of the current school year/summer camp session.

Signature of Physician/Dentist	Date	Phone number
Print physician's/dentist's name		

**SECTION III (Record of administration of medication/treatment)**

Date and time of dosage/treatment	Amount of Dosage	Signature of staff member