Bristow Montessori School
Medical Authorization Form

Instructions:
- **Section A** must be completed by parent/guardian for **ALL medication authorizations** - prescription and over-the-counter medications, short and long-term use.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 work days).

**Section A: To be completed by parent/guardian for ALL medications - prescription and over the counter medications, short and long-term use.**

**Medication authorization for:**

(Child’s Name)

Bristow Montessori School has permission to administer the following medications:

**Medication Name:**

**Dosage and Times to be administered:**

**Special Instructions (if any):**

This authorization is effective from: ______________________ until: ______________________

(start date) (end date)

**Parent or Guardian**

Signature: ______________________ Date: ______________________

If prescription label is missing on short term prescription medication:

**Physician Signature:** ______________________ Date: ______________________

**Physician Phone Number:** (____) ______

**Section B: to be completed by child’s physician for long term medications (longer than 10 work days) - prescription and over the counter medications.**

I, ______________________ (Physician’s Name) certify that it is medically necessary for medication listed below to be administered to: ______________________ (Child’s Name) for a duration that exceeds 10 work days.

**Medication(s) Name:**

**Dosage and Times to be administered:**

**Special Instructions (if any):**

This authorization is effective from: ______________________ until: ______________________

(start date) (end date)

**Physician Signature:** ______________________ Date: ______________________

Physician Phone Number: (____) ______