



MEDICATION AUTHORIZATION

Please complete either Part 1 or Part 2.

Part 1

As parent/guardian of the child listed below, I grant my permission to Virgin Islands Montessori School to administer over-the-counter medication to my child to help reduce fever, alleviate headache or any other minor pain/discomfort my child is experiencing at the time, should it be deemed necessary after every attempt has been made to reach me and other emergency contact persons as listed on the yellow Registration Card. The over-the-counter medications will be either Children's Tylenol or Advil in either liquid or tablet form.

Note: My child is allergic to Children's Tylenol/Advil. I give permission for the following over-the-counter medication to be administered instead: _____

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

Part 2

I do NOT give permission to Virgin Islands Montessori School to administer over-the-counter medications to my child, even after all attempts to reach me and other emergency contact persons as listed on the yellow Registration Card have been unsuccessful.

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____